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ABSTRACT

Major long-term public policy issues related to the aging of the U.S. population are examined. Chapter one provides an overview of trends pertaining to the future elderly population, emphasizing some of the issues Congress may need to address in the near future. Sources of support for the elderly are also examined. Employment and retirement issues are the foci of the second chapter. The key policy issue discussed is how to provide cost-effective incentives to an increasing proportion of healthy elderly who can work in a productive economy free of age discrimination and without penalizing those who must retire early. Chapter three discusses the allocation of health care resources. It points out that Congress will have to struggle to balance issues such as government regulation, quality, freedom of choice, effectiveness, efficiency, and equity across society as it makes policy in this area. The concluding chapter deals with long-term care, defined as helping people live their lives rather than as extended medical care. Also provided are brief highlights of legislation affecting the elderly and a bibliography. (RM)

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TOMORROW'S ELDERLY

A REPORT

PREPARED BY THE

CONGRESSIONAL CLEARINGHOUSE
ON THE FUTURE

FOR THE CHAIRMAN

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES
NINETY-EIGHTH CONGRESS
SECOND SESSION

OCTOBER 1984

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PREFACE

As Chairman of the Select Committee on Aging it is my firm belief that by looking at tomorrow's problems and opportunities today, future problems can be averted and future opportunities can be seized. This booklet is the product of the Congressional Clearinghouse on the Future. Even though the Committee does not ordinarily publish documents that are not prepared by the Committee, this booklet gives us both an historical perspective and vision for the future, and I believe an exception is warranted in this case.

This booklet identifies major, long-term, public policy issues related to the aging of the U.S. population. It scans key long-range trends pertaining to the future elderly population emphasizing some of the issues Congress may need to address in the near future.

This booklet is organized around the presentation of trends and issues. In general, the data are summarized in a short headline or paragraph, supporting trend data are shown in graphic form, major issues arising from the data are discussed, unresolved questions are raised, and illustrative policy options are presented. The policy options are given to stimulate thought, discussion, and exploration; they are not comprehensive, nor are they endorsed by the Congressional Clearinghouse on the Future, the House Select Committee on Aging or any other group or individual who helped in preparing this document.

The data and projections presented here are primarily from the established Federal statistical agencies such as the Bureau of the Census, the Bureau of Labor Statistics, the Health Care Financing Administration and the National Center for Health Statistics. No original data collection or data analysis was performed for this project.

Commendations are due to all involved in the preparation of this document. I believe that this booklet provides a substantive framework in which to consider these various public issues. I am hopeful that the dissemination of this booklet will contribute to a better conceptualization of the needs of our aging United States population and better public policy in behalf of the elderly.

Edward R. Roybal
Chairman

Tomorrow's Elderly

Issues for Congress

Prepared for
The House Select Committee on Aging
by
The Congressional Clearinghouse on the Future
September 1984

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FOREWORD

Congress faces some of the most emotional issues of our time as it looks at the needs of the elderly and the government's role in meeting those needs. The American population is aging. Regardless of birth and immigration rates, there are going to be more elderly people in our country in the future.

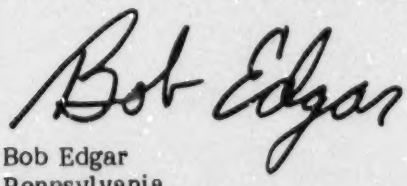
This is very good news, because it means people are living longer on the average. However, the aging of our society also poses extremely difficult questions: Do we need to rethink our definition of "old age" and our attitudes about the elderly? What can and will elderly individuals and their families do alone or with the help of the private sector to support and care for the elderly? What must government do? And from the young: Who will support us when we're old?

In answering these questions, Congress will have to address how to maintain commitments to the elderly, assure fairness across generations, cope with escalating health care costs, protect against an uncertain economic future, and restore and maintain a balanced federal budget.

The underlying philosophy of this discussion is that the elderly have the same desires as the rest of the population:

- A respected place in the community with no discrimination because of age, sex, race, or religion;
- Healthful living and working conditions and good quality health care when needed;
- Opportunity to work for a fair wage during their healthy lifetime, with employment suitable to their mental and physical abilities; and
- Economic support when retired or unable to work because of ill health or disability.

We are examining long-term trends and issues so that Congress can act to influence the future rather than wait and be overwhelmed by demographic realities. If we act now rather than later, then we all — employer and employee, parent and child, government and citizen — will participate in a better future.



Bob Edgar
Pennsylvania
Chairman, Congressional
Clearinghouse on the Future

ACKNOWLEDGEMENTS

The Congressional Clearinghouse on the Future wishes to acknowledge the important contributions made by a number of people in the preparation of this policy primer. First and foremost, the Clearinghouse thanks Elaine Bunten-Mines, a Commerce Science and Technology Fellow, who coordinated the study and wrote and edited the report. Without her commitment, "Tomorrow's Elderly" would not have been possible.

The Select Committee on Aging of the U.S. House of Representatives initiated this study by asking the question, "What trends will be important to our committee and the Congress in coming years?" The Committee's staff director, Jorge J. Lambrinos, and Geo. Allen Johnston, Gary Christopherson, and Lowell Arye provided valuable comments and expert, technical advice on substantive issues. Special mention also is in order to Elizabeth Bagnato who typed and prepared this document for printing.

A team of experts and consultants at the U.S. General Accounting Office conducted the research and developed the charts used in the report. Special thanks go to Ken Hunter who provided important support and guidance; to Hal Wallach and Audrey Clayton who managed the team; and to their outside consultants Sara Rix, Haeworth Robertson, Beth Soldo, and John Deshaies; and to the able research assistance of Emily Agree, Pauline Mahon-Stetson and Cheryl Malanick.

Several other Congressional staff members reviewed the drafts and provided invaluable technical and editorial assistance. The staff director of the Senate Special Committee on Aging, John Rother, and a member of his staff, Betsy Vierck, were especially helpful and cooperative. Special thanks also go to Betina Schiebler, a staff member of U.S. Representative Buddy MacKay and to the staff of U.S. Representative Bob Edgar who reviewed the policy primer: Dean Kaplan, Richard Fuller, Skip Powers, and John Briscoe.

From the Clearinghouse, Lena Lupica the Director, and Elaine Wicker deserve special mention for their vision and support of the effort and their review of many drafts of the report.

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Tomorrow's Elderly

EXECUTIVE SUMMARY

The aging of the American population is no longer news. The increasing numbers of elderly people in our society, and particularly, the increasing numbers of very old citizens require the Congress to examine several public policy areas and, in all likelihood, to act on its findings.

Some of the most important trends are summarized in the accompanying charts. These demonstrate that:

o The elderly are expected to make up an increasing proportion of the U.S. population through the middle of the next century. By that time, one person in five is expected to be 65 or older.

o Higher proportions of the elderly population will be female and over age 85.

o Because women marry younger than men and outlive men, on the average, most elderly women are widows and most elderly men are married and live with their wives. Elderly women living alone tend to be poorer and at greater risk of institutionalization than the general population of elderly.

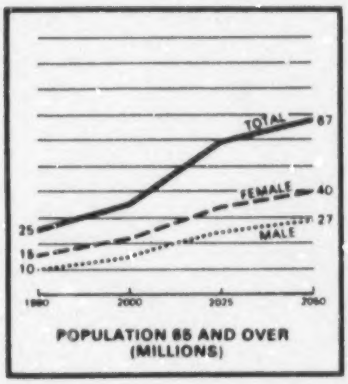
o While the elderly as a group have about the same rates of poverty as the general population, blacks, women, and the very old, and those living alone have higher than average poverty rates. Members of more than one subgroup (e.g., elderly black women living alone) tend to have extremely high poverty rates.

o Social Security benefits are and will continue to be the largest single source of income for most elderly citizens, even though income from pensions and assets may become more important in the future to higher income groups than it is today.

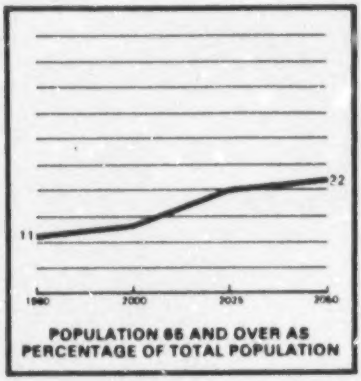
o Over the past 20 years, costs for programs that benefit the elderly have grown rapidly. These programs will face the same pressures for cost containment as other programs in the federal budget. There will be increasing scrutiny of elderly programs, because the "senior boom" -- when the "baby boom" reaches retirement age early in the next century — will place enormous pressures on programs that benefit the elderly.

This public policy primer looks at three issues that are most likely to need Congressional action in the next decade if we are to prepare for the senior boom in the 21st century.

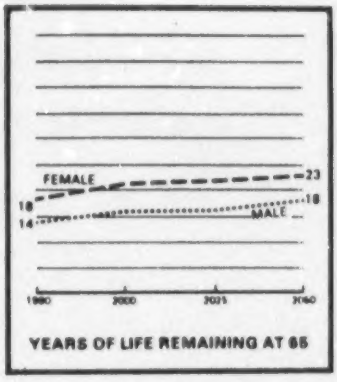
PROJECTED DEMOGRAPHIC TRENDS FOR THE ELDERLY 1980-2050



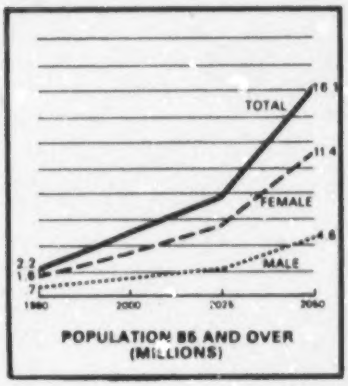
POPULATION 65 AND OVER (MILLIONS)



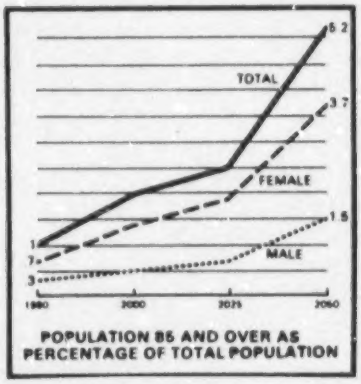
POPULATION 65 AND OVER AS PERCENTAGE OF TOTAL POPULATION



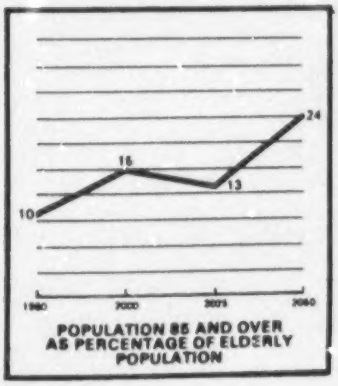
YEARS OF LIFE REMAINING AT 65



POPULATION 85 AND OVER (MILLIONS)

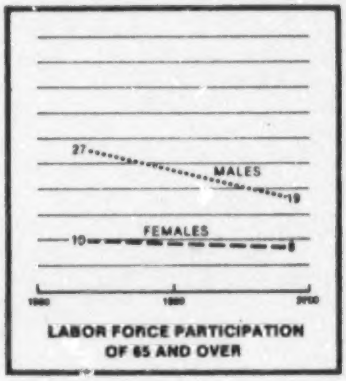


POPULATION 85 AND OVER AS PERCENTAGE OF TOTAL POPULATION

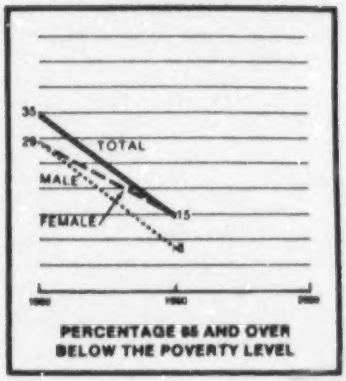


POPULATION 85 AND OVER AS PERCENTAGE OF ELDERLY POPULATION

HISTORIC AND PROJECTED TRENDS IN SOCIAL AND ECONOMIC CHARACTERISTICS OF THE ELDERLY 1960-2000

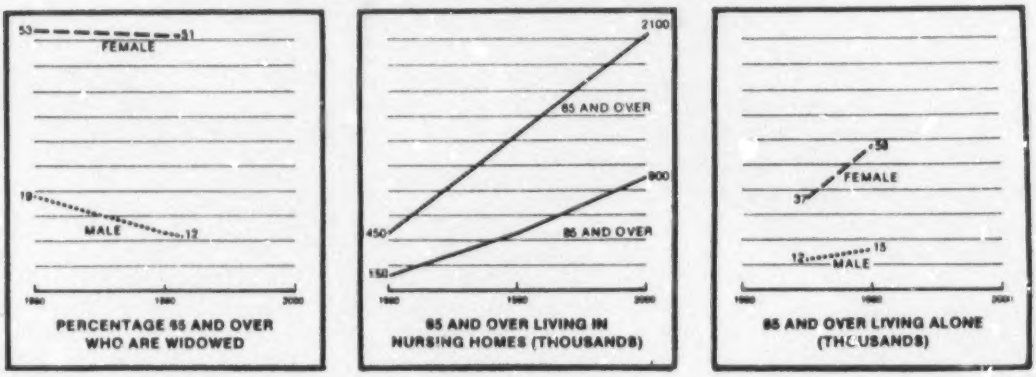


LABOR FORCE PARTICIPATION OF 65 AND OVER



PERCENTAGE 65 AND OVER BELOW THE POVERTY LEVEL

HISTORIC AND PROJECTED TRENDS IN SOCIAL AND ECONOMIC CHARACTERISTICS OF THE ELDERLY 1960-2000



Employment and Retirement

The declining population of entry-level workers (18-24) for the balance of the century and the increasing population of elderly people may require a revision of laws and regulations related to older workers and retirement.

Even with the growth in private pension coverage and the increased incentives and awareness of the need for individual savings, Social Security is expected to continue to be the preeminent source of retirement income for the foreseeable future. Currently, the Social Security system is projected to build huge surpluses during the 1990s and the first decade of the next century. However, increased longevity, low birth rates, and a continued trend toward early retirement could exhaust those surpluses during the retirement lifetimes of younger workers who will enter the labor force later in this century.

One of the most significant trends of the past 50 years has been the decline in labor force participation on the part of the elderly. Currently, there are many incentives for older workers to leave the work force at relatively young ages (55-64). Statistics confirm that leaving the job before age 65 has become the norm. Yet people are living longer on the average. By the end of this century, it may be necessary to provide greater incentives for older workers to remain in the work force longer if we are to have enough skilled workers to run our businesses and to support those who cannot work.

Allocation of Health Care Resources

Costs of health care in this country have increased at a startling rate for everyone. However, since the elderly are major users of health care services, the high rate of inflation in health care costs has imposed a special burden on the elderly and the government programs which provide health care for them.

In 1984, the elderly will spend more of their income on health care than before Medicare and Medicaid began. This proportion is projected to continue increasing for the foreseeable future. The 1984 report of the Medicare Board of Trustees also projects a problematic future for Medicare. Despite the significant cutbacks legislated in the early 1980s, the Medicare hospital trust fund will run out of funds around 1990 if no action is taken.

Congress is considering a number of measures related to controlling health care costs generally, with Medicare payments serving as a target. The biggest causes of past cost increases include: inflation; an increase in the number of tests, medical services, and surgical services per patient; use of new technologies; and lack of incentives to control costs. Since little agreement exists about the proper mix of responsibility among the individual, family, insurer, physician, hospital, and government, the next decade is likely to be a living experiment in policymaking aimed at determining how much services should cost and who should pay for which services.

For the next 25 years most of projected health care cost increases will be due not to increases in the elderly population but to the same factors which have pushed costs up over the last decade. After 2010, the senior boom will begin and the number of people eligible for Medicare will climb rapidly. Therefore, it is imperative that the key to containing health care costs be found in this century.

Long-Term Care

The number of elderly people needing long-term care is expected to rise sharply in the next several decades because of the growing numbers of people over the age of 85 and the growing numbers of elderly living alone.

Long-term care is commonly associated with medical problems. However, much of the need for long-term assistance is simply related to an inability to perform one or more of the tasks of everyday living (eating, bathing, etc.) rather than to some treatable medical condition. Since most long-term care is given at home by the family, the elderly who live alone are especially vulnerable to institutionalization.

The need for public help in providing long-term care is expected to grow because the traditional care-givers — adult women — are increasingly working outside the home and are not as likely to be available for full-time care in the future. Currently, public support for long-term care is very limited and is biased toward medical treatment/ institutional care and away from home support services and family assistance.

Tomorrow's Elderly

CHAPTER ONE

OVERVIEW OF TRENDS

Economic, demographic, and social trends can be used to paint a general picture of the elderly population today and in the future. The trends shown on the next few pages are related to the key characteristics of the elderly population and sources of support for that population. The trends create a context for the policy discussions which follow.

DEFINITION: In this booklet, the term "elderly" refers to individuals 65 years old or older. Those 85 years or older are referred to as "very old".

As we use these terms, however, it is important to note that one consequence of an aging population may be the need to continue to redefine such terms. The "elderly" population is extremely diverse and "old age" cannot be defined by chronological age alone.

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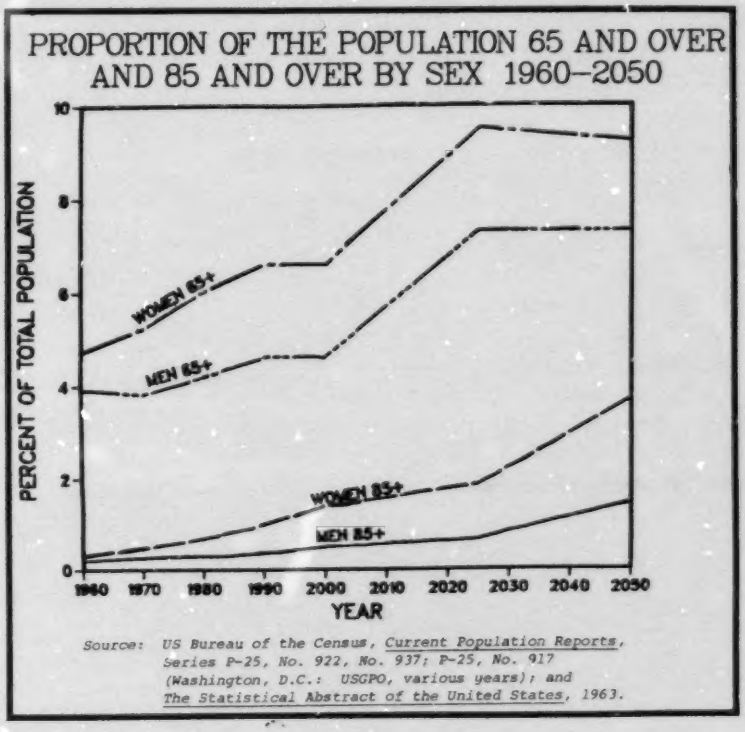
KEY CHARACTERISTICS OF THE ELDERLY

1. THE BABY BOOM WILL BE FOLLOWED BY THE SENIOR BOOM.

The number of elderly in the United States has grown rapidly in the last 20 years (twice as fast as the rest of the population). However, for the next twenty-five years, the relative growth of the elderly population will be much more gradual. After 2010, as the "baby boomers" begin to reach 65, the "senior boom" will explode.

In 1960, just 1 person in 10 was over 65 (16.5 million people). By the middle of the next century, 1 person in 5 is expected to be over 65 (67 million people), a four-fold increase in less than a century.



Source: US Bureau of the Census, Current Population Reports, Series P-25, No. 922, No. 937; P-25, No. 917 (Washington, D.C.: USGPO, various years); and The Statistical Abstract of the United States, 1963.

2. THE VERY OLD ARE THE FASTEST GROWING AGE GROUP IN THE U.S.

At the beginning of this century, about 4 percent of the elderly were 85 or older. By the middle of the next century, nearly a quarter of the elderly are expected to be 85 or older. In terms of the total U.S. population, that means that more than one American in 20 is expected to be 85 years old or older in the year 2050. Life expectancy has increased by 27.5 years since the turn of the century — from 47 years to 74.5 years — an increase that nearly equals the gain for the previous 5000 years.

GROWTH OF THE VERY OLD AS A PERCENTAGE OF THE ELDERLY POPULATION

Year	85+ as Percent of All Elderly	85+ as Percent of Total Population	Number of 85+ in Population
1900	4	0.2	123,000
1950	5	0.4	577,000
1980	10	1.0	2,200,000
2000	15	1.9	5,136,000
2025	13	2.5	7,700,000
2050	24	5.2	16,063,000

Source: US Bureau of the Census, "Population Estimates and Projections," Current Population Reports, Series P-25, No. 922 (Washington, D.C.: USGPO, 1982).

3. THE ELDERLY POPULATION IS INCREASINGLY FEMALE.

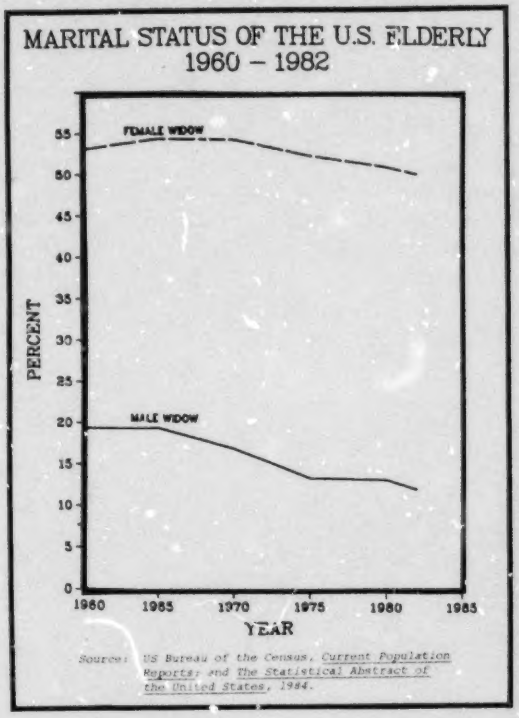
The life expectancy of U.S. women continues to increase faster than that of men. Between 1950 and 1982, U.S. female life expectancy increased from 71.1 years to 78.2 years (a gain of 7.1 years). During the same period, male life expectancy increased from 65.6 years to 70.8 years (a gain of 5.2 years). About 50 percent of the under-65 population is female, increasing to about 60 percent of the 65+ population, and about 70 percent of the 85+ population. This male-female imbalance is expected to continue to grow. By the year 2000, for example, 73 percent of the 85+ population may be female.

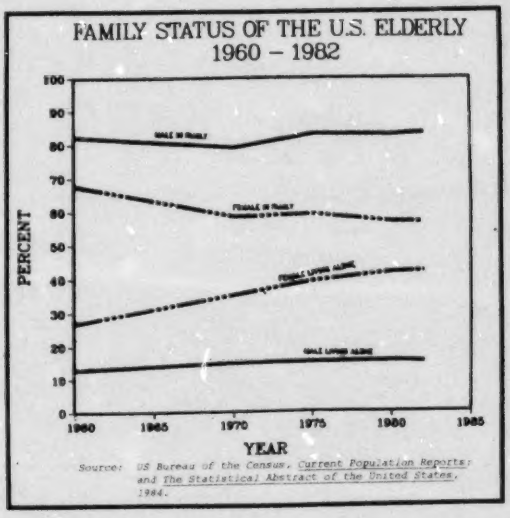
4. MOST ELDERLY MEN ARE MARRIED AND LIVE IN A FAMILY; MOST ELDERLY WOMEN ARE WIDOWS AND MANY LIVE ALONE.

Only 12 percent of elderly men were widowers in 1982 while 51 percent of elderly women were widows. Among those 75 years old and older, 70 percent of men were married and 70 percent of women were widows. Since women tend to marry at a younger age than men and female life expectancy is growing faster than that of men, this trend is expected to intensify in the future.

The percentage of widowed elderly women appears to be stable or declining. However, the number of widows is expected to continue to increase in the future because of an increasing differential between life expectancy of men and women.

Over the past 20 years, the percentage of elderly men living in a family has remained fairly constant at just over 80 percent. In contrast, the percentage of elderly women living in a family has declined and the percentage living alone has risen steadily. Today, about one-third of the elderly live alone and the percentage is increasing, particularly for women. Eighty percent of the elderly who live alone are women.



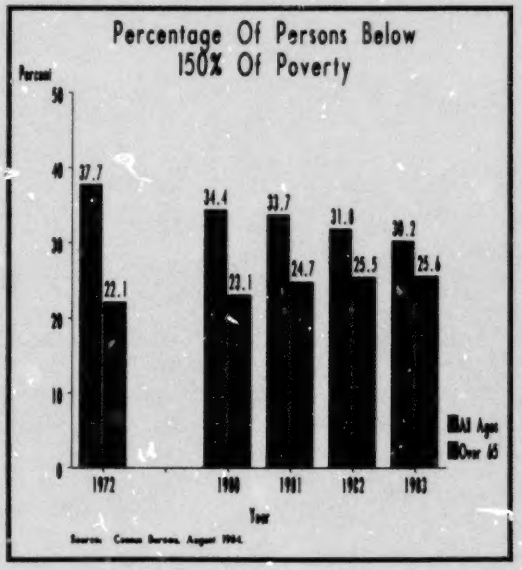


5. POVERTY RATES HAVE BEEN REDUCED, BUT MANY ELDERLY ARE STILL POOR.

In 1972, the percentage of poor and near poor elderly (under 150 percent of poverty) was 38 percent as compared to 22 percent for the whole population. Although the percentage of poor and near poor elderly has been declining since 1972, the percentage (30.2 percent) is still higher than for the population as a whole (25.6 percent) in 1983.

Despite the gains to levels slightly above the official poverty line ($1667 in 1968, $4626 in 1982), many elderly are still "just getting by." Furthermore, certain elderly subgroups continue to have poverty rates two to three times as high as the population as a whole.

The elderly subgroups with the highest poverty rates are among those elderly that are growing the fastest: women, the very old, and persons living alone. Although they are not among the fastest growing groups, blacks are particularly vulnerable to poverty in old age, with a poverty rate about three times the rate for elderly whites. Individuals who are members of two or more of these high risk subgroups are much more likely to be poor.



1982 POVERTY RATES FOR SELECTED ELDERLY SUBGROUPS

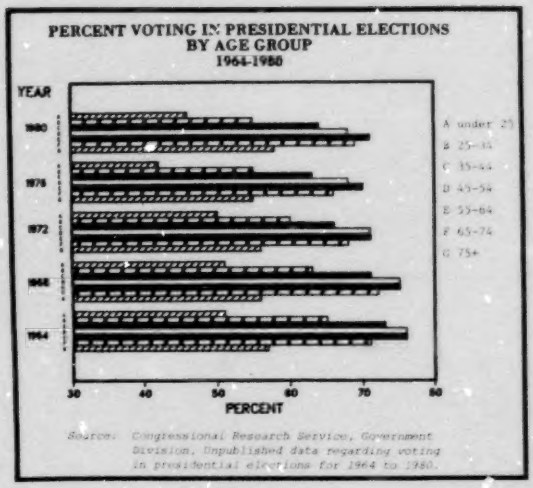
Percent Below Poverty Level	Elderly Subgroup
15	All Elderly
18	Elderly Women
28	Elderly Living Alone
42	Elderly Blacks
66	Elderly Black Women Living Alone

Source: US Bureau of the Census, Poverty Division Unpublished Data, 1984.

6. OLDER CITIZENS TEND TO HAVE MORE ACTIVE VOTING PATTERNS THAN THE YOUNG.

In the last five presidential elections, the peak voting group has been the 55-64 age group (roughly 70 percent voting), with the 45-54 and 65-74 age groups vying for second place. Over this same period, citizens 75 and older voted in greater proportion than the under 25 age group.

These trends in voting patterns are expected to continue — perhaps intensify — in the future.

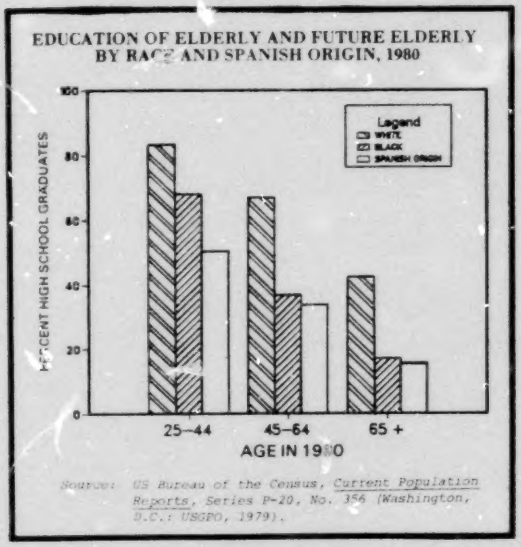


Source: Congressional Research Service, Government Division, Unpublished data regarding voting in presidential elections for 1964 to 1980.

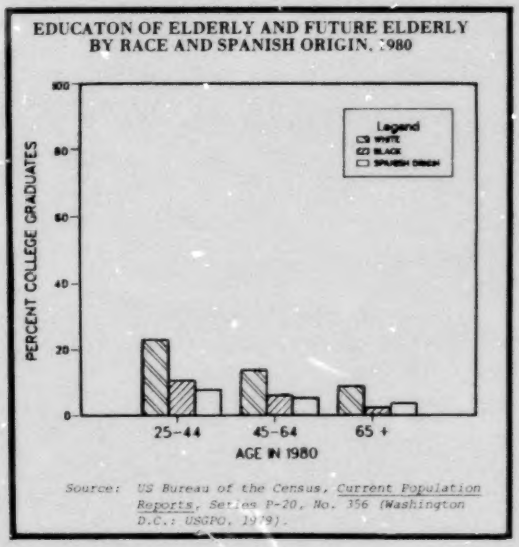
7. THE FUTURE ELDERLY WILL BE BETTER EDUCATED.

In 1982, more than 40 percent of the elderly had finished high school, in comparison with less than 20 percent of the elderly in 1960. There were comparable increases in the percentage of college graduates. Since more of today's under-65 population are finishing high school and going to college, and the median number of years of schooling is increasing (now over 12.5 years), tomorrow's elderly are expected to be better educated than today's.

Better education is important because it is related to other factors: those who are better educated tend to earn more in their lifetimes and to stay in the work force longer.



Source: US Bureau of the Census, Current Population Reports, Series P-20, No. 356 (Washington, D.C.: USGPO, 1979).



Source: US Bureau of the Census, Current Population Reports, Series P-20, No. 356 (Washington D.C.: USGPO, 1979).

SOURCES OF SUPPORT FOR THE ELDERLY

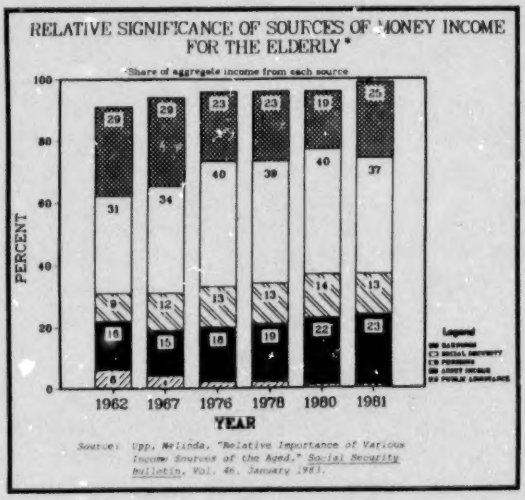
Prior to the establishment of the Social Security system, the primary sources of support for the elderly were income from family and employment. Since the 1930s, most experts have tended to discuss retirement income as a three-legged stool made up of Social Security benefits, savings, and pensions despite the fact that earnings from employment have provided a greater source of income than all other sources except Social Security. In the next century, income from employment will become an even more important and better recognized source of income for the elderly.

1. SOCIAL SECURITY WILL CONTINUE TO BE THE LARGEST SINGLE SOURCE OF INCOME.

More than 9 out of 10 of the elderly received Social Security benefits in 1981, with 65 percent relying on Social Security for half or more of their total income.

The importance of Social Security income increases for the elderly subgroups who are most vulnerable: the very old, blacks, and women living alone. In 1981, Social Security accounted for about 37 percent of money income for the average elderly individual and for nearly 80 percent of the cash income of the low-income elderly (those with incomes of $5000 or less). One-fifth of the elderly living alone and two-fifths of the black elderly living alone received 90 percent or more of their income from Social Security.

A majority of elderly families can expect over half of their income to come from Social Security at the turn of the century.



2. EARNINGS CONTINUE TO BE AN IMPORTANT INCOME SOURCE.

Even though there is a growing trend toward early retirement, earnings from employment continue to be the second largest single source of income for the elderly (25 percent of income for all elderly in 1981). As the level of income decreases, so does the contribution of earnings.

Future trends related to employment income for individuals 65 and older will be addressed more fully in the chapter entitled "Employment and Retirement."

3. ASSET INCOME MAY BECOME MORE IMPORTANT TO HIGHER-INCOME ELDERLY.

In 1979, only about 6 percent of the elderly received income from savings and other assets and most of them reported less than $1,000 of income from that source. However, since income from assets amounted to 20 percent of the overall income of the elderly some elderly do have significant savings.

Future retirees may have a better opportunity to build assets due to the liberalization of the eligibility rules for establishing Individual Retirement Accounts (IRAs). Use of IRAs increased from 3.4 million (7 percent of those eligible) in 1981 to 12.1 million (17 percent of those eligible) in 1983.

Although the long-term impacts on savings are still uncertain, initial studies indicate that IRAs may not be encouraging new savings and investment. In 1982, more than half of all funds placed in IRAs came from current savings rather than new savings.

Research shows IRA use:

- o is concentrated among high income groups;
- o is not as evenly distributed across income levels as employer-sponsored pensions;
- o increases with age;
- o is more likely to be selected by women than men.

In sum, even though IRAs could have a positive effect on the asset income of future retirees overall, IRA's primary effects would be concentrated on today's upper income group.

4. ABOUT HALF OF PRIVATE SECTOR EMPLOYEES ARE COVERED BY PENSION PROGRAMS; ABOUT ONE-FOURTH WILL RECEIVE PENSIONS.

As of 1983, about 50 percent of all private industry employees 18 years old and older were covered by pensions in their current jobs. That percentage is expected to be stable for the foreseeable future. If past behavior continues, about half of the covered workers or one-fourth of all workers can expect to receive pensions when they reach retirement age.

Among today's elderly, about 28 percent of men and 10 percent of women actually receive pensions. Average annual payments are about $4200 and $2400 per year, respectively.

Labor unions have been a major driving force behind the establishment and growth of private pension plans in the past. Union membership has been declining in recent decades and many of the new "knowledge" industries are less unionized than the basic industries. To the extent that union membership is an indication of pension coverage, the percentage of pension coverage is not expected to grow greatly in coming years.

On the other hand, greater numbers of women in today's workforce will result in more elderly women in the future who have pensions of their own. Between 1979 and 1983, 3.3 million women were added to the non-agricultural labor force and 1.2 women gained entitlement to future retirement benefits. However, many women workers still have work patterns and occupations that do not lead to maximum pension coverage. Recent changes in laws affecting pension programs could also cause the number of people covered by private pensions to grow somewhat (e.g., requiring a company to continue to vest workers during maternity or paternity leave, lowering the age at which work counts toward vesting, and allowing pensions to be allocated as part of divorce settlements).

This topic is discussed more fully in the section entitled "Employment and Retirement"

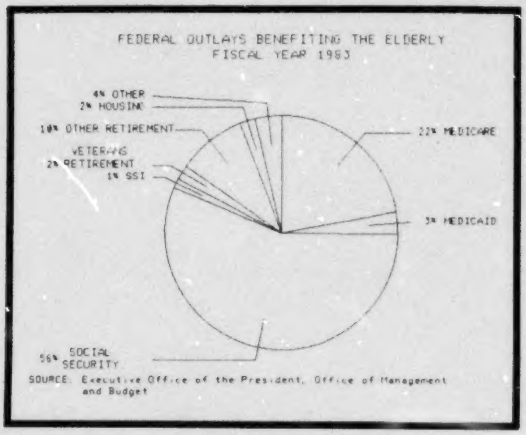
5. TODAY, FEW POOR ELDERLY APPLY FOR PUBLIC ASSISTANCE; TOMORROW, MORE ELDERLY MAY APPLY.

Very few elderly people participate in public assistance programs today and only a small portion of cash income comes from that source. In 1981, only half of the elderly with incomes below the poverty line received public assistance.

The Supplemental Security Income program (SSI), a federal program with state supplements, provides most public assistance income for the elderly, but this program has a very low elderly participation rate. The reasons for low participation by the elderly in public assistance programs are not fully explained. In part, low participation is said to be caused by an inability to deal with the system and by an unwillingness to accept "welfare".

In addition to cash contributions, the government provides benefits to the elderly in the form of medical care, food stamps, publicly-owned or subsidized rental housing, and energy assistance. These benefits have expanded markedly in the past few years, from $10 billion in 1971 to over $60 billion in 1983.

The future elderly, who will have grown up with much greater exposure to public assistance programs, may be more adept at dealing with the system and may feel less stigma from accepting such assistance.



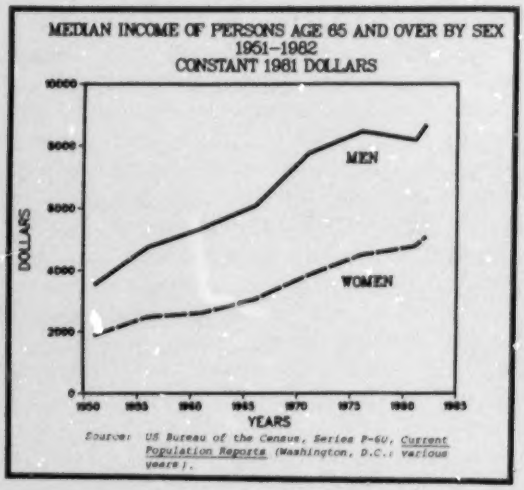
6. SOURCES OF ELDERLY INCOME ARE RELATED TO INCOME LEVELS.

Elderly people with low and moderate incomes — most of the elderly — get the majority of their income from Social Security. At incomes above $12,000 per year, earnings become an important income source.

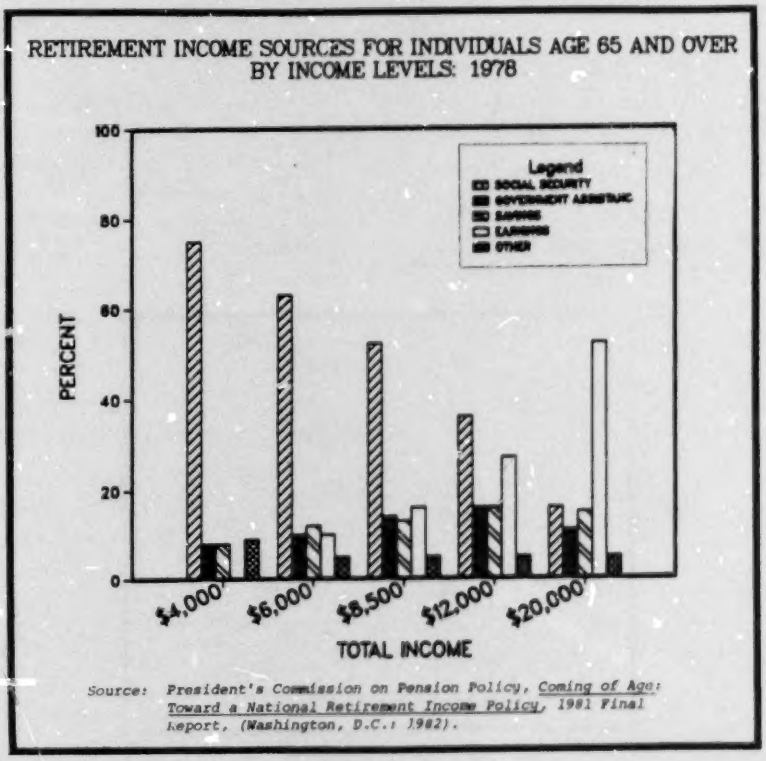
7. ELDERLY INCOME IS MODEST; HALF OF WOMEN AND BLACKS ARE BELOW $5000.

On the average, income for elderly individuals is modest, but men have much higher incomes than women, and whites have much higher incomes than blacks.

In 1981, about half of elderly white women and black men — and 80 percent of black women — had incomes below $5000.



Source: US Bureau of the Census, Series P-60, Current Population Reports (Washington, D.C.: various years).



Source: President's Commission on Pension Policy, Coming of Age: Toward a National Retirement Income Policy, 1981 Final Report, (Washington, D.C.: 1982).

Tomorrow's Elderly

CHAPTER TWO

EMPLOYMENT AND RETIREMENT

Concerns over the future costs of Social Security, federal retirement and other income programs for the elderly, lead policy-makers to consider ways to prolong labor force participation. Any incentive to keep older workers in the labor force must compete successfully with the growing trend of early retirement. On the other hand, provisions such as those in the 1983 Social Security Amendments to raise retirement age from 65 to 67 after the turn of the century may penalize those who, because of health, discrimination, or unemployment, are forced to retire early with reduced benefits.

A key policy question for the future is how to provide cost-effective incentives to an increasing proportion of healthy elderly who can work in a productive economy free of age discrimination and without penalizing those who must retire early.

WHAT ARE THE FACTS?

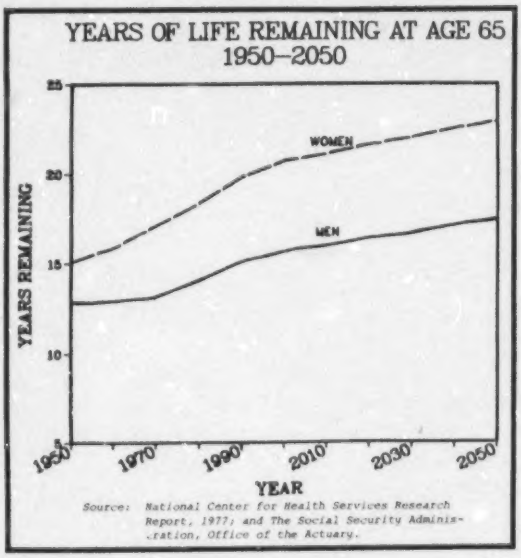
MEN ARE LIVING LONGER, BUT RETIRING EARLIER
WOMEN ARE WORKING FOR PAY LONGER

Life expectancy continues to increase. By the year 2000, men can expect to live 10-15 years after reaching age 65 while women can expect to live 15-20 more years. Physical and mental capabilities do not automatically deteriorate at 65. So, for an increasing proportion of people, life after 65 can be productive and less constrained by functional limitations. Accordingly, the number and quality of years that persons over 65 can expect to live has prompted a review of what constitutes "normal" career and retirement patterns.

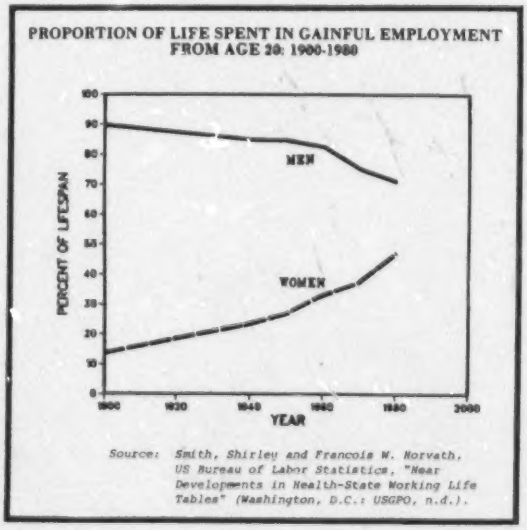
As men live longer, they are spending a smaller portion of their lifespans in the labor force even though the number of years they work is longer. For example, a man born in 1900 could expect to live about 46 years. He would work for 32 years (69 percent) and be retired for only about 1 year (3 percent). A man born in 1981 can expect to live about 70 years. He will work for 38 years (55 percent) and be retired for about 14 years (30 percent).

In 1983, the labor force participation rate for elderly men stood at 17 percent down from 46 percent in 1950. From 1970 to 1983, the rate for men aged 55-to-64 dropped from 83 percent to 69 percent.

Women are both living longer and working for pay longer than their predecessors. As women live longer, they are spending a smaller portion of their lives in child bearing and rearing. A woman born in 1900 could expect to spend 18 years of her 48-year lifespan (37 percent) bearing children; a woman



Source: National Center for Health Services Research Report, 1977; and The Social Security Administration, Office of the Actuary.

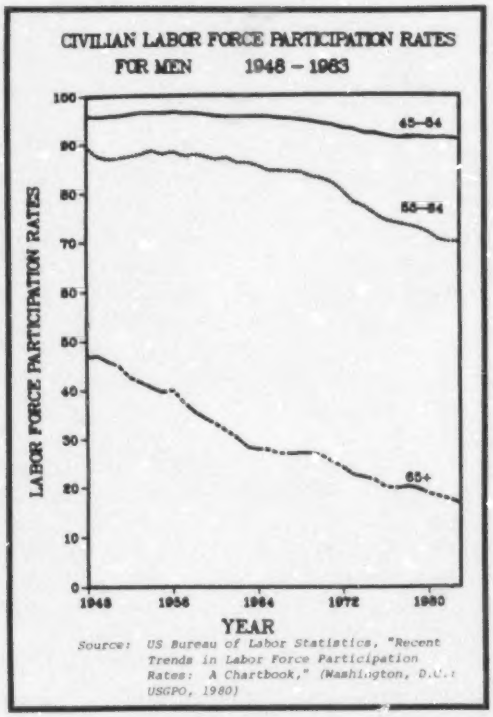


Source: Smith, Shirley and Francois W. Horvath, US Bureau of Labor Statistics, "Near Developments in Health-State Working Life Tables" (Washington, D.C.: USGPO, n.d.).

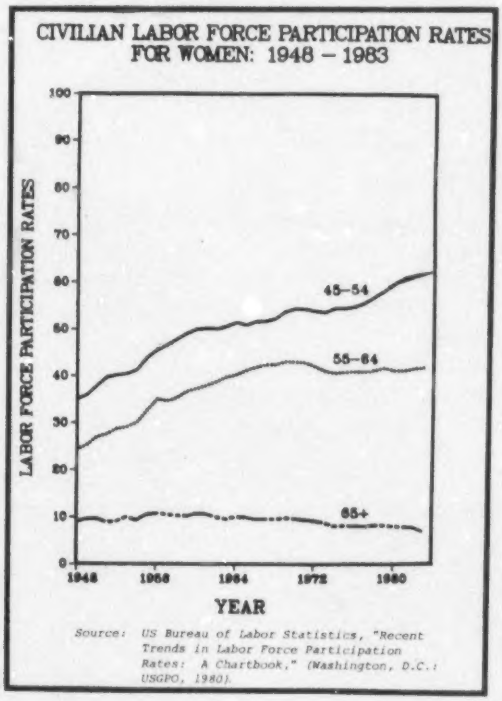
born in 1981 can expect to spend only 10 years of her 78-year lifespan (13 percent) bearing children. In the future, more of the job of rearing those children will be shared with others.

Women's labor force participation reached a new high of 52.9 percent in 1983 (48.5 million women), up from 52.6 percent in 1982. This is a slower rate of growth than in the decade of the 1970s when there was an increase of more than 1 million women every year. Middle-aged women (45-54) have increased their labor force participation rates from 38 percent to 62 percent since 1950. The rate for women aged 55-64 went from 27 to 42 percent. The overall female labor participation rate is projected to reach 65 percent by 1995. The increases in labor force participation among younger and middle-aged women have not been translated into an increase in participation at the upper ages. As of 1983, only 7 percent of all women 65 and older were in the labor force, down somewhat from the 10 percent of 1950.

There are numerous factors in an individual's decision to retire, but the decision tends to be based primarily on health status and the availability and level of potential retirement income. Mandatory retirement rules probably do not account for much of the male labor force withdrawal since the trend toward retirement is pronounced in the pre-65 labor force.



Source: US Bureau of Labor Statistics, "Recent Trends in Labor Force Participation Rates: A Chartbook," (Washington, D.C.: USGPO, 1980)

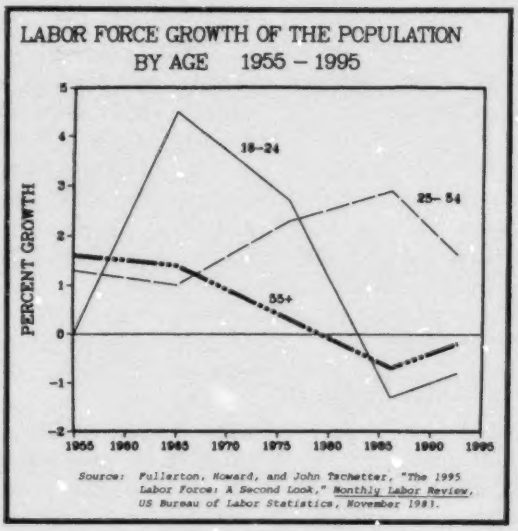


Source: US Bureau of Labor Statistics, "Recent Trends in Labor Force Participation Rates: A Chartbook," (Washington, D.C.: USGPO, 1980).

WHAT ARE THE FACTS?

U.S. LABOR FORCE WILL CHANGE DRAMATICALLY IN THE NEXT DECADE

Labor force growth for all of this century is likely to be very different from the pattern of the 50s, 60s, and 70s. Nearly all the growth in the next two decades will be middle-aged adults. Between 1980 and 1995, workers aged 25-54 will increase by almost 30 million while both younger and older age groups will decline. The number of workers 16-24 will drop by over 4 million.



Experts do not agree on the effects of these growth patterns on the employment of older workers. Some analysts argue that the impending shortage of young workers will be an incentive for employers to retain or hire older workers. Others argue that the enormous increase in workers in their prime working years could be a "surge from below" that will tend to push older workers out of the labor force.

WHY IS THIS ISSUE DIFFICULT?

EXPERTS DISAGREE ON THE ECONOMY'S ABILITY TO CREATE JOBS

The economy of the United States has been in serious straits for the last ten to twelve years, with lower productivity growth, sharper competition from abroad for markets, sharply higher energy prices, high inflation and high unemployment. Federal budget deficits are at historical high points. Business and government leaders have been struggling to find the mix of policies that will lead to economic growth and full employment. In this environment, projections about the longer-term performance of the economy are extremely uncertain.

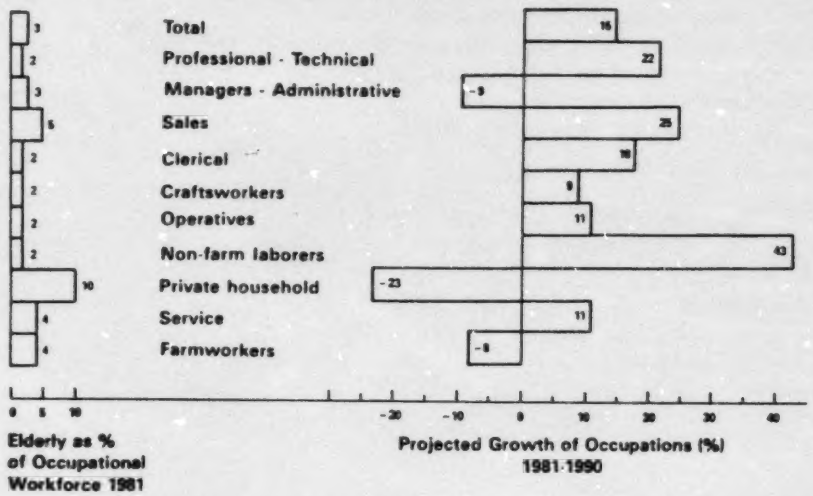
One of the central uncertainties in the jobs debate is the potential impact of technological advances on job opportunities. Some analysts predict that the introduction of new technologies will result in many new jobs. Other analysts predict that the new technologies will produce a net job loss.

In an expanding economy, much of the concern about jobs disappears, but few economists anticipate a return to the unprecedented growth rates of the 1950s and 1960s, when a rapidly expanding economy and low inflation

provided jobs for almost all who wanted them and improved retirement benefits for those who wanted to retire. But some economists are projecting dramatic expansion for the economy toward the end of this century. If the economy should expand rapidly, the older more experienced workers could be leading the boom. According to some, employment in the service sector may grow by 31 percent between 1981 and 1990. Even though the goods-producing industry will grow more slowly, employment there is expected to grow by 13 percent. Among occupations, the Bureau of Labor Statistics expects growth to be greatest for professional and technical workers, service workers and clerical workers.

The uncertain economic future is bringing considerable disagreement on whether a sufficient number of jobs will be available through the end of the century to accommodate the available supply of workers. With a bumper crop of middle-aged workers on the horizon, many question whether it would be wise to provide incentives that encourage older workers to stay in the labor force.

PROJECTED GROWTH OF OCCUPATIONS AND CURRENT ELDERLY PARTICIPATION

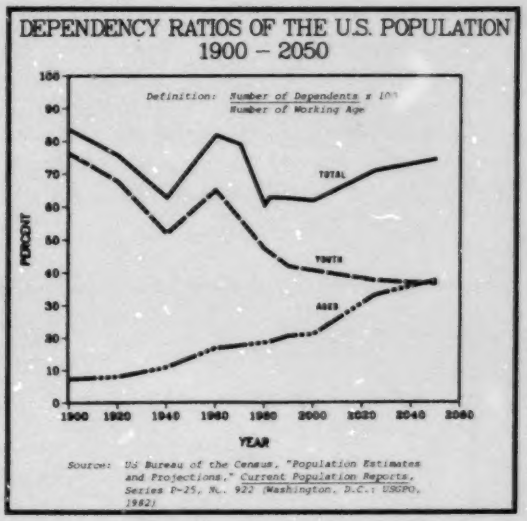


Source: *Max, Carey, "Occupational Employment Growth Through 1990," Monthly Labor Review, August 1981.*

WHY IS THIS ISSUE DIFFICULT?

DEPENDENT POPULATION WILL GROW AT FASTER RATES THAN WORKING AGE POPULATION

The conventional way of looking at the burden on workers is through the "dependency ratio" or "support ratio". This ratio compares the number of people of "working age" (18-64) to the number of dependent young (under 18) and the number of elderly (over 64).



Although there will be a slight increase in the ratio of those regarded as dependents to those of working age, the dependency ratio looks promising over the remainder of this century. Many analysts believe that continuing low birth rates in the coming decades will completely offset the increase in elderly citizens so that the total number of dependents will remain stable. Nevertheless, since elderly dependents require more resources than an equivalent number of dependent children, there will be increasing demands upon the working age population.

After the year 2010, the senior dependency ratio may become a problem for Social Security. For example, the SSA projects that the ratio of tax payers to beneficiaries will have dropped from 3.2 in the early 1980s to 2.2 by 2025 — a decline of about one-third.

WHY IS THIS ISSUE DIFFICULT?

RETIREMENT AND PENSION POLICIES AND ATTITUDES MAY BE BASED ON YESTERDAY'S STATISTICS AND EXPECTATIONS

Earned Benefits

The Social Security and Medicare systems are financed on a pay-as-you-go basis, as is the pattern in most developed nations. Current benefits are funded from current income rather than from payments contributed by and for those individuals during their working years. This system worked well in the climate of economic prosperity following World War II when the number of workers paying into the system was growing rapidly and the number of retirees was low. However, such programs will be adversely affected by poor economic environment, the higher elderly dependency ratio, and the increase in the life expectancy of retirees during the 1970s.

Congress has passed legislation to increase income to the system and over the next three decades to build up a surplus for the senior boom in the next century. Between now and 2010, there will be only a moderate growth in the number of Social Security beneficiaries. With the increases in payroll taxes already scheduled, a surplus should accrue in the Social Security Trust Fund that would provide adequate support to Social Security retirees into the next century.

Since they have paid into the system over many years, most Social Security recipients look at their benefits as earned benefits. At the same time, however, the average beneficiary will continue to receive more from Social Security than is contributed in payroll taxes.

Early Retirement

In the 1950s, many pension programs were changed to encourage older workers to retire, in the belief that the total number of jobs in the economy was fixed and younger workers needed jobs the most. Even though the U.S. economy has created jobs at an exceptional rate in the 1970s, and even though the number of elderly non-workers has increased dramatically in comparison to the numbers of workers of all ages, many people continue to believe that it is better to move older workers into retirement to "free up" jobs for younger workers.

Many companies use various incentives to ease their workers age 55 and over into retirement. With the upcoming growth in the workforce aged 35-54, there will be less room at the top than usual and more competition for mid- and high-level positions. Such competition may intensify the feelings of younger workers that the older workers should leave and "make room" for the next generation. In medium- and large-sized firms, more than 90 percent of white-collar workers can retire by age 55, if they have served the required number of years. Among blue-collar workers, 80 percent could retire by age 55. Some companies supplement the early retiree's income until he or she is eligible for Social Security benefits.

Other incentives include:

o A growing perception that the economy may not get better and that the

wiser course of action is to retire with a better benefit package than might be available at some later time. (However, the perception is somewhat offset by uncertainty in the economy and fears of what inflation might do to a fixed retirement pension.)

o Older workers in low wage jobs tend to retire earlier as the Social Security payments replace a larger proportion of low wage earners' pre-retirement income.

o Only a small proportion of private retirement plans (6 percent) increase the size of pension or monthly payment to account for working beyond the normal retirement age. (Social Security, for example, provides only a slight credit for delayed retirement.)

Coverage

Labor unions have been a major driving force behind the establishment and growth of private pension plans in the past. Union membership has been declining in recent decades and many of the new "knowledge" industries are less unionized than the basic industries. To the extent that pension coverage is affected by union membership, the percentage of coverage is not expected to grow greatly in coming years.

On the other hand, greater numbers of women in today's workforce should result in more elderly women in the future who have pensions of their own. Recent changes in laws affecting pension programs could also cause the number of people covered by pensions to grow somewhat (e.g., requiring a company to continue to vest workers during maternity or paternity leave, lowering the age at which work counts toward vesting, and allowing pensions to be allocated as part of divorce settlements). However, many women workers still have work patterns and occupations that do not lead to maximum pension coverage.

Effects of Inflation

Very few private pension plans (only about 3 percent) provide for cost of living increases. Yet an annual inflation rate of 5 percent for 15 years can erode the real value of private pension benefit by about one-half. An inflation rate of 10 percent for 15 years would reduce the benefit to one-quarter of its original value. Inflation is the greatest threat to those who depend on private pensions and assets.

SUMMARY

The employment and retirement decisions of the elderly and near-elderly could have a major impact on the solvency of pension and Social Security programs. Unfortunately, there is major uncertainty about the economic future of the country and about the combined effects of countervailing trends.

On the one hand, we should expect to experience increased public costs of retirement as a consequence of increased life expectancy and a continuation of an historic trend toward earlier retirement. On the other hand, a shrinking supply of entry-level youth and the potential need for greater experience and skill in the workforce may lead to an enhanced receptivity to maintaining older workers in the workforce.

Experts disagree as to projections about the overall economic future, including the nature of the future workforce and labor demand by occupation and industry. It may be necessary to monitor and analyze the interactions of a broad spectrum of driving forces before it will be possible to develop coherent public policies in this area.

UNANSWERED QUESTIONS

1. How do we define "a reasonable standard of living" for the elderly?

2. What is the appropriate degree of public-private coordination with respect to retirement policy?

3. What is the purpose of Social Security? Should it provide a minimum benefit level or be used as the primary retirement income?

4. What are the trade-offs between adequacy and equity in our retirement income system?

5. Will present contributors to Social Security payroll taxes receive what they believe to be a fair rate of return when they retire?

6. Can workers be expected to assume greater responsibility for their own retirement support?

7. To what extent do higher payments to Social Security payroll taxes substitute for other savings or investment by employees, by employers?

8. What is an appropriate mix of public and private sources of income? What portion of retirement income should be earned by saving, investing, or paying into Social Security or a pension plan?

9. Should the government attempt to provide incentives or disincentives to employers that will result in more widespread participation in private pension programs? Greater incentives for individual savings?

10. As a result of changes in the age composition of the labor force and other factors, what will be the demand for older workers? Will there be a need to encourage their continuation in the labor force? Will older workers be asked to perform entry level jobs usually filled by younger people?

11. How will increased introduction of robotics and automation impact productivity, quality of life, and the numbers and types of employees in various industries and occupations?

12. What kind of jobs will characterize the economy of the future? Will older workers be suited to those jobs? Could they be retrained?

OPTIONS

The option statements presented on the next few pages are intended to stimulate thought and discussion. They are not comprehensive, nor are they endorsed by the Congressional Clearinghouse on the Future, the House Select Committee on Aging, or any other organization or individual involved in the preparation of this report. Their sole purpose is to introduce the reader to the variety and scope of options that have been raised in this area, so understanding and useful debate will be enhanced.

CAUTION: The options shown here are not endorsed by the House Select Committee on Aging or the Congressional Clearinghouse on the Future; they are presented for information and discussion only.

ISSUE AREA: EMPLOYMENT AND RETIREMENT

OBJECTIVE: Provide incentives and remove disincentives for older workers who want to stay in the labor force and maintain supply of workers.

ILLUSTRATIVE OPTION 1	ILLUSTRATIVE OPTION 2	ILLUSTRATIVE OPTION 3
Encourage the increased availability of part-time employment and other flexible work options for older workers.	Further liberalize the penalty paid by current Social Security recipients under 70 with annual wages above $6960.	Provide greater incentives to encourage prolonged labor force participation by increasing the credit given for delayed retirement beyond that incorporated in the 1983 amendments.
PROS	**PROS**	**PROS**
1. Maintains skilled workforce adequate for producing goods and services for the nation. 2. Softens shock of retirement (psychological and, possibly, financial). 3. Older people who work tend to have higher living standard and cushion against inflation.	1. Would remove penalty for working. 2. Could encourage delayed retirement. 3. Would increase revenues from income taxes.	1. Would encourage delayed retirement, but allow early retirement.
CONS	**CONS**	**CONS**
1. May reduce the number of jobs available for the younger population.	1. Would benefit the most affluent of the elderly. 2. Would require significant additional federal outlays ($2 billion in 1984). 3. Might have little impact on elderly labor force participation.	1. Would increase costs.

CAUTION: The options shown here are not endorsed by the House Select Committee on Aging or the Congressional Clearinghouse on the Future; they are presented for information and discussion only.

ISSUE AREA: EMPLOYMENT AND RETIREMENT

OBJECTIVE: Provide incentives and remove disincentives for older workers who want to stay in the labor force and maintain supply of workers.

ILLUSTRATIVE OPTION 4

Foster more full-time employment on the part of women, and/or revise immigration policies.

PROS

1. Could offset shrinking pool of young entry-level workers.
2. Could avoid need to reverse trend to earlier retirement, maintaining freedom of choice for elderly.

CONS

1. Immigration policy is a sensitive and controversial issue.

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ISSUE AREA: EMPLOYMENT AND RETIREMENT		
OBJECTIVE: Minimize hardship to elderly due to technological innovation, etc.	OBJECTIVE: Spread the costs and benefits of Social Security more evenly across society.	OBJECTIVE: Improve the financial position of the Social Security System.
ILLUSTRATIVE OPTION 1	ILLUSTRATIVE OPTION 1	ILLUSTRATIVE OPTION 1
Devise retraining incentives (e.g., tax credits to employers), to enhance employability of older workers.	Change the basis for Social Security funding so that it is financed equally by the employee, the employer and the Federal Government instead of by the first two only.	Make Social Security a more progressive program by increasing benefits to lower income groups and decreasing them for higher groups.
PROS	PROS	PROS
1. Would maintain productive work force. 2. Would increase supply of marketable workers.	1. Would lower the highly visible payroll tax on employer and employee. 2. Perceived savings might be used by employers to expand private pension systems, hire additional workers, and invest in the industry.	1. Could reduce government costs. 2. Would focus resources on the truly needy.
CONS	CONS	CONS
1. Could increase costs. 2. Employers tend to take only the "cream", not those most in need of retraining.	1. Would mask long-term solvency problems of Social Security system. 2. May erode workers' perceptions that benefits are directly linked to their employment.	1. Politically explosive. 2. Would violate existing "contracts".

Tomorrow's Elderly

CHAPTER THREE

ALLOCATION OF HEALTH CARE RESOURCES

Costs for health care in this country have increased at a startling rate across the board, not just for the elderly. However, the elderly population is a major user of health care services and, because the elderly population is increasing — particularly the 85+ group — there are fears:

- Fears on the part of the elderly that as out-of-pocket health care costs continue to increase and as current health care support is reduced, they will be unable to afford the care they need.
- Fears on the part of the young that by the time they become beneficiaries of Medicare, the system will be insolvent or restructured, and they will receive fewer benefits than do current beneficiaries.
- Fears on the part of Congress and the Executive Branch that rising health care costs will lead to insolvency of the Medicare Trust Fund or to larger federal budget deficits, or both.

This is an area in which we do not have the luxury of lead-time: the problem is immediate. It is also an area in which there are no clear, easy answers. Congress will have to struggle to balance issues such as government regulation, quality, freedom of choice, effectiveness, efficiency, and equity across society as it makes policy in this area.

WHAT ARE MEDICARE AND MEDICAID?

MEDICARE

Medicare is a federal program that was created in 1965 to help pay the health costs of older Americans and the disabled. All elderly Social Security and railroad retirement recipients are eligible for Medicare. Elderly individuals who are not entitled to automatic hospital coverage may purchase the Hospital Insurance.

—Medicare Part A (Hospital Insurance or HI) covers hospital costs, hospice costs and short term (less than 100 days) nursing home and home health costs. Part A is financed by a portion of the Social Security payroll tax. Recipients are responsible for a $356 annual deductible and for copayments during long hospital or nursing home stays.

—Medicare Part B (Supplemental Medical Insurance or SMI) covers physician services, hospital out-patient services, laboratory, and other medical services. Part B is partially financed (25 percent) through monthly fees paid by the recipients and partially (75 percent) through general tax revenues. In 1984, recipients paid $14.60 per month. Recipients are responsible for a $75 annual deductible and 20 percent coinsurance on covered services.

In addition to the limits on long-term care and home care, Medicare does not cover eye examinations and eyeglasses, hearing examinations and hearing aids, drugs, and routine dental treatments and dentures.

MEDICAID

Medicaid is a federal and state program that helps certain low-income individuals of all ages get medical care. Eligible individuals include recipients of Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI), and may include those receiving other cash assistance or needing nursing home care. In 1980, 16 percent of Medicaid recipients were elderly and 37 percent of program costs were for elderly recipients.

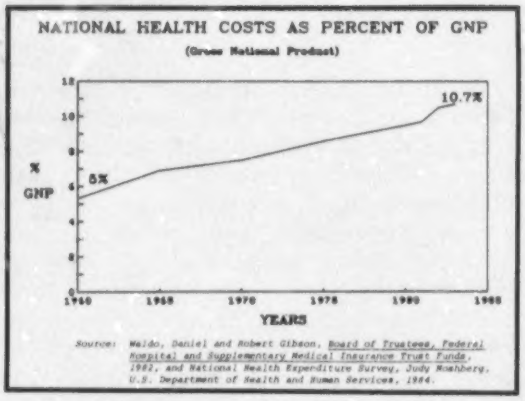
Medicaid covers a wide range of medical services including hospitalization, physician care, laboratory, and x-rays. Unlike Medicare, Medicaid pays long-term nursing home costs. Nursing home costs represent about 75 percent of the Medicaid costs for the elderly.

As of 1981, the federal government was paying 55 percent of total Medicaid costs. In that year and several subsequent years, Congress voted to reduce federal payments to the states for Medicaid. Although those reductions are scheduled to end as of fiscal year 1984, the percentage the federal government will pay of total Medicaid costs is expected to remain in the 55 percent range.

WHAT ARE THE FACTS?

HEALTH CARE IS TAKING MORE OF OUR NATIONAL INCOME.

National health care costs — for all services, for people of all ages — have been growing faster than our national economy for many years. In 1960, about 5 percent of our Gross National Product (GNP) went for health care; in 1983, nearly 11 percent of GNP went for health care. Total national spending in 1984 will be about $350 billion. About one-third of that total ($120 billion) will go to meet the health needs of the Nation's 28.5 million elderly citizens.

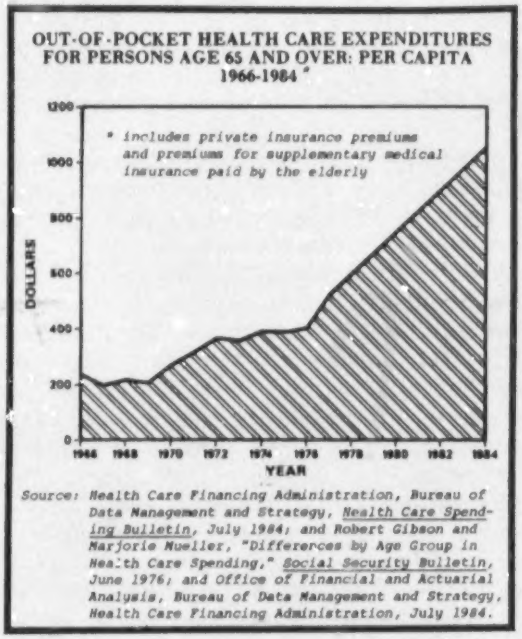

NATIONAL HEALTH COSTS AS PERCENT OF GNP
(Gross National Product)
%
GNP
5%
10.7%
YEARS
Source: Waldo, Daniel and Robert Gibson, Board of Trustees, Federal Hospital and Supplementary Medical Insurance Trust Funds, 1982, and National Health Expenditure Survey, Judy Mohlberg, U.S. Department of Health and Human Services, 1984.

HEALTH CARE IS TAKING MORE OF THE FEDERAL BUDGET.

In 1970, about 9 percent of the total Federal budget went for health care; in 1985, about 11 percent of the budget will be for this purpose. Medicare payments alone have grown from less than 4 percent of federal budget outlays in 1970 to an estimated 6.7 percent in 1985.

HEALTH CARE IS TAKING MORE DIRECTLY OUT OF THE ELDERLY'S POCKETS.

In 1984, elderly individuals will spend an average of $1526 out of their own pockets (including Medicare premiums), about 15 percent of their total income. This is a higher proportion than they were paying before Medicare and Medicaid were enacted, and will continue to increase in the future.


OUT-OF-POCKET HEALTH CARE EXPENDITURES FOR PERSONS AGE 65 AND OVER: PER CAPITA 1966-1984 *
* includes private insurance premiums and premiums for supplementary medical insurance paid by the elderly
DOLLARS
YEAR
Source: Health Care Financing Administration, Bureau of Data Management and Strategy, Health Care Spending Bulletin, July 1984; and Robert Gibson and Marjorie Mueller, "Differences by Age Group in Health Care Spending," Social Security Bulletin, June 1976; and Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration, July 1984.

WHAT ARE THE FACTS?

MEDICARE COSTS COULD MORE THAN DOUBLE BY 1990
MEDICARE GROWTH WILL CONTINUE AT A SLOWER RATE

Medicare and Medicaid are the two federal programs which have financed large portions of the health care services for the elderly. From relatively modest beginnings, both of these programs have grown to major proportions. For example, Medicaid paid a little over $1 billion in support of the elderly in 1972 and almost $6 billion in 1982. Medicare has grown from $4.7 billion in 1967 to $52.2 billion in 1982. Projections to the year 1990 show an increase to $132 billion in Medicare spending. Though the increase is high, the average rate of increase for the 1982-1990 period is expected to be less than 12.5 percent — a much lower rate than the average for the 1975-1982 period of 18.9 percent.

Despite recent increases in cost-sharing, new cost-saving provisions, and a reduced rate of inflation for medical expenses, Medicare costs are still expected to grow at a rate faster than the economy, the elderly's income, or the federal budget during the 1980s. The Hospital Insurance Trust Fund of Medicare (Part A) is expected to be depleted by the end of the decade. The total costs of Medicare Part B are expected to increase by nearly 16 percent per year through 1988, much faster than elderly income, the economy, the federal budget, or general tax revenues. Thus, both the elderly and the entire Medicare program are expected to be in financial difficulty by the end of the decade.

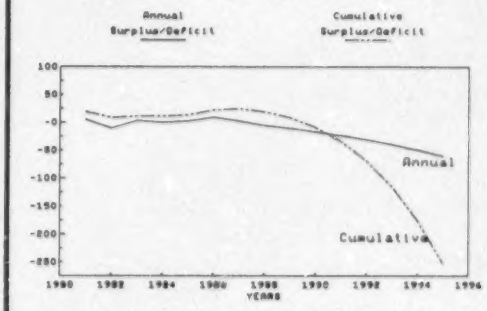
MEDICARE BENEFIT PAYMENTS 1967-1990

CALENDAR YEAR	TOTAL PAYMENTS ($,B)	ANNUAL PERCENT CHANGE	HOSPITAL CARE ($,B)	ANNUAL PERCENT CHANGE
		HISTORICAL		
1967	4.5	-----	3.1	-----
1968	5.7	26	3.8	21
1969	6.6	16	4.5	20
1970	7.1	8	5.1	12
1971	7.9	11	5.7	13
1972	8.6	10	6.4	11
1973	9.6	11	7.1	12
1974	12.4	30	9.3	30
1975	15.6	26	11.6	25
1976	18.4	18	13.8	18
1977	21.8	18	16.3	18
1978	24.9	15	18.4	14
1979	29.3	18	21.2	15
1980	35.7	22	26.0	22
1981	43.5	22	31.3	21
1982	50.9	17	36.3	16
		PROJECTED		
1984	66.5	14	46.1	13
1987	94.7	12	64.6	12
1990	131.5	12	88.7	11

Source: *Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Financial and Actuarial Analysis; and M. Freeland and C. Schendler, Health Care Financing Review, Spring 1984, Volume 5, Number 3.*

SURPLUS/DEFICIT IN MEDICARE PART A

(Hospital Insurance Trust Fund Balance 1981-1998)



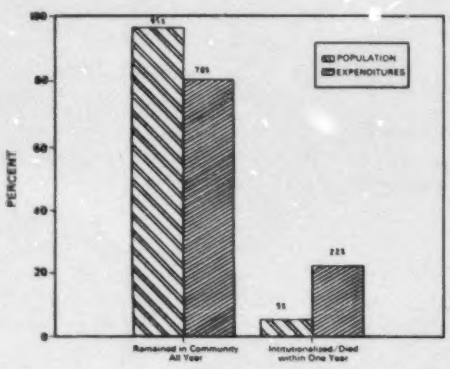
Source: CBO estimates based on February 1983 budget and economic assumptions, but updated to reflect the Social Security Amendments of 1983 (Public Law 98-21).

WHAT ARE THE FACTS?

THE ELDERLY NEED AND SPEND MORE ON HEALTH CARE THAN THE NON-ELDERLY.

The elderly have more severe and chronic illnesses and more disability than the non-elderly. As a result, the elderly as a group accounted for about 11 percent of the overall population and about one-third of the nation's health care costs in 1981. Per capita health care expenditures were estimated at $828 for persons under age 65 and $3140 for persons 65 and over. Even when nursing home costs are removed from the calculation, per capita expenditures for elderly individuals in 1981 were still three times those for the younger population.

PROPORTION OF ELDERLY LIVING IN THE COMMUNITY AND LEVEL OF HEALTH EXPENDITURES



Source: "Expenditures for the Medical Care of Elderly People Living in the Community Throughout 1980," National Medical Utilization and Expenditure Survey, Data Report, No. 4, DHHS, No. 84-2000 (Washington, D.C.: USGPO, November 1983)

A SMALL GROUP NEEDS A LARGE AMOUNT OF CARE AND ACCOUNTS FOR A MAJOR PORTION OF COSTS.

Most health care costs occur during the last two years of life, regardless of the age at death. Since the majority of deaths occur in the elderly population, this is one major reason why the elderly account for a high proportion of overall health care costs. Even among the elderly, however, nearly all (95 percent) live in the community in a given year and a large majority of these (75 percent) spend less than $1000 per year on health care services such as hospitals and home care.

A very small group of the elderly accounts for a large proportion of the expenditures. In 1980, for example, 5 percent of the elderly accounted for 22 percent of elderly health care expenditures. Medicare and Medicaid expenditures are even more concentrated on a small proportion of the users — primarily those receiving hospital or nursing home care.

WHY IS THIS A DIFFICULT ISSUE?

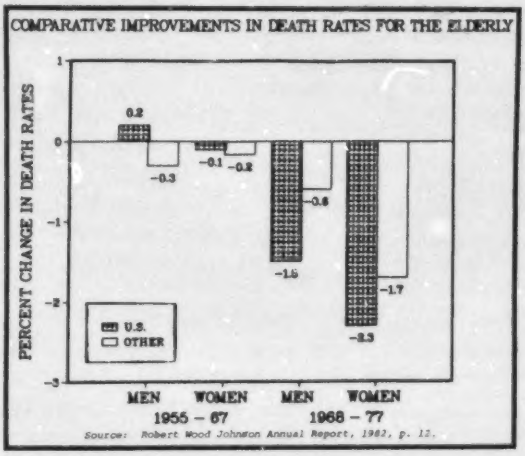
MEDICARE AND MEDICAID HAVE HAD POSITIVE RESULTS

Prior to the inception of Medicare and Medicaid, many of the elderly could not afford adequate medical care. One-third of the elderly had no health insurance prior to 1965. The elderly were spending nearly 15 percent of their income on health care.

Between 1955 and 1967, death rates for U.S. elderly were falling at a lower rate than in the developed European countries. For the decade after the introduction of Medicare and Medicaid, death rates for the elderly in the U.S. fell at a faster rate than in the European countries.

Some analysts argue that the various age groups of the elderly population are healthier than their counterparts were in earlier decades. However, chronic disease and disability statistics demonstrate that the numbers and proportions of frail elderly are increasing. The comparative health status of yesterday's, today's, and tomorrow's elderly is a topic of current debate.

The gap in use of health care services between the poor and non-poor elderly has been substantially narrowed. It should be noted that even equal use would not necessarily result in adequate care since the poor elderly tend to be in poorer health than the overall elderly population and need more health care.



ACCESS TO HEALTH CARE: 1980

	Number of Physician Visits	Proportion Hospitalized During the Year	Total Costs
Poor Elderly	5.0	16%	No significant difference
Nonpoor Elderly	5.4	19%	

Source: "Current Estimates from the Health Interview Survey: US 1980," Vital and Health Statistics, Series 10, National Center for Health Statistics (Washington, D.C.: USGPO, 1980).

WHY IS THIS A DIFFICULT ISSUE?

HEALTH CARE COSTS ARE INCREASING FOR ALL AGE GROUPS

It will be difficult to bring Medicare and Medicaid costs under control because these programs are subject to the same general factors that are making health care costs rise for all groups in the population: inflation, an increase in services per beneficiary, use of costly new medical technology, and lack of incentives to control costs. Contrary to popular perception, the least important factor in cost increases between now and 1995 will be the increase in the elderly population.

INFLATION ACCOUNTS FOR MORE THAN HALF OF COST INCREASES.

Inflation is the single most important contributor to the growth of health care costs in the last decade. Between 1972 and 1982, an estimated 58 percent of the increase in health care costs was attributable to general inflation.

If general inflation continues at its current lower rate, the rate of increase in health care costs should also slow. However, medical care price inflation has also been a major contributor and will have to be dealt with separately. In 1983, medical care price inflation rose twice as fast as general inflation.

SERVICE INTENSITY ACCOUNTS FOR A QUARTER OF MEDICARE INCREASES

The rise in volume of services per beneficiary is the second most important cause of increases in Medicare costs. The Office of Technology Assessment (OTA) estimates that 24 percent of the 93 percent increase in per capita hospital costs between 1977 and 1982 can be attributed to an increase in the use of covered services.

On the average, Medicare-covered hospital patients are given more hospital services, medical and surgical services, drugs, and medical devices than the general hospital population. Though the elderly generally need more care, a portion of the high use of hospital services may result from a lack of incentives to use less expensive ambulatory care and from the desire of providers to maintain high hospital occupancy.

NEW TECHNOLOGY

Medical technology is a major factor in increasing health care costs. Medicare's policies are a key factor in the adoption and use of these technologies. The cost attributable to technology changes is difficult to estimate since it is closely tied to changes in intensity of care. In addition, new technology can be judged appropriate or inappropriate only in terms of whether or not it improves the quality of care. However, there is an intense debate over whether or not an assessment of new technology must consider its impact both on health status and on cost.

LACK OF INCENTIVES TO CONTROL COST

Third-Party Financing

Most third-party financing of health care is said to insulate the patient from considering the cost when making decisions about services and to insulate the physician from concern about the patient's ability to pay for services. This

"distance" from the costs can lead to an increase in the numbers of procedures and tests performed and, particularly, to an increase in high-cost procedures.

Medicare already requires that the elderly pay a significant proportion of the costs of their care. In addition to serious questions about the ability of the elderly to pay more, recent studies indicate that additional Medicare cost sharing would not be likely to slow cost growth.

Medicare's new prospective payment system attempts to control costs without increasing cost-sharing by the elderly. Through the fixed-reimbursement-per-admission (Diagnostic Related Grouping — DRG) schedule, Medicare is seeking to reverse the incentives provided by the previous Medicare payment plan. Earlier, providers were reimbursed for each service for each patient, regardless of total cost.

Reimbursement For Procedures Rather Than Results

Physicians are reimbursed for procedures performed, tests completed, physician visits, etc., rather than for beneficial outcomes. Hospitals are currently reimbursed on the basis of an admission for a particular diagnosis. Very little is known about the relative risks and benefits associated with many standard procedures (medical and surgical) used by physicians and hospitals, and what little is known is not well disseminated.

By tradition, physicians have a great deal of discretion in the treatment of their patients. For example, the individual physician usually determines whether or not a patient will be hospitalized. There are large differences among regions of the U.S. in the use of hospitals by Medicare patients. For example, North Dakota has a hospital discharge rate nearly twice that found in Maryland. In addition, several studies have shown that the kinds and costs of hospital treatment in a community are more related to the numbers of physicians and their specialties than to the health of the population.

Thus, many analysts believe that the supply of physicians and specialists — which is expected to grow over the next decade — and their methods of prescribing treatments will have a great deal to do with the general increase in health care costs in this country.

GROWTH OF ELDERLY POPULATION WILL BE LESS IMPORTANT UNTIL 2010

The number of elderly people eligible for Medicare and Medicaid jumped during the last 20 years. Those new recipients have also been a factor in increasing costs. However, between now and 2010, new recipients will increase only gradually. The Congressional Budget Office has estimated that only a small percentage of the projected annual 13.2 percent growth in hospital reimbursements between 1984 and 1995 will be due to an increase in the elderly population. After 2010, when the number of elderly begins to rise sharply, health care costs can be expected to rise accordingly.

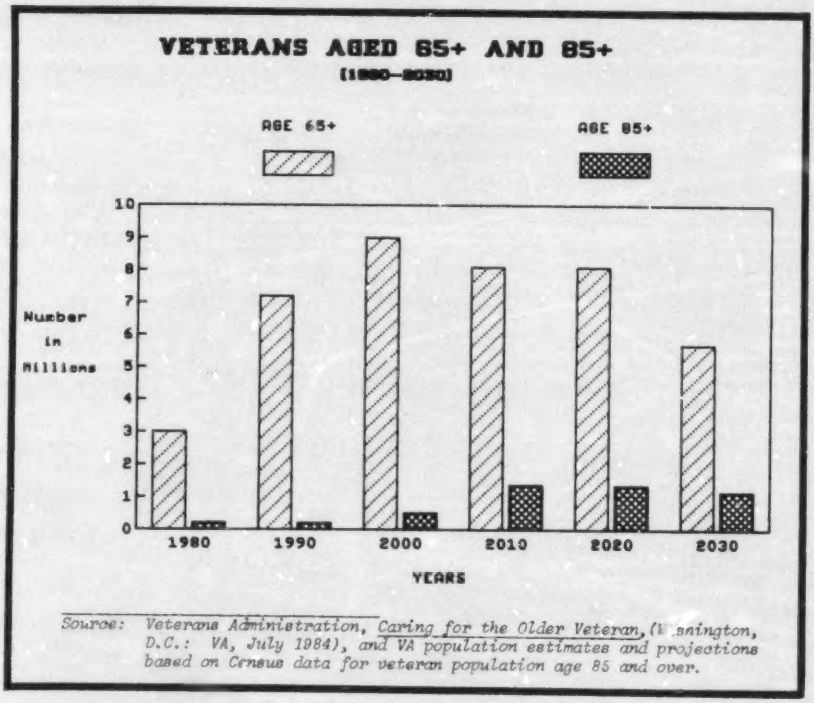
VETERANS HEALTH CARE — A SPECIAL CASE

SURGE OF ELDERLY VETERANS WILL STRAIN THE VA HEALTH CARE SYSTEM

Veterans of World War II and the Korean War will be turning 65 and becoming eligible for VA-provided or supported health care between now and 2000. The number of veterans 65 and older will more than double in the next 15 years (from 4 to 9 million) and the number 85 and older will grow from about 260,000 to about 515,000.

Since VA hospitals and nursing homes already have an 85 percent occupancy rate and many nursing homes have waiting lists, the VA health care system will be hard-pressed to meet the projected demand without major changes.

Options for dealing with projected demands for service are highly controversial. However, the boom in the veteran population will require solutions to be formulated and enacted in the near term.



Source: Veterans Administration, Caring for the Older Veteran, (Washington, D.C.: VA, July 1984), and VA population estimates and projections based on Census data for veteran population age 85 and over.

SUMMARY

In the last 20 years, the U.S. has changed from a country in which most elderly citizens paid for their own health care services or did without (and many did without) to a country in which most elderly citizens have better access to and significant government support for health care. At the same time, the U.S. has experienced an unprecedented increase in health care costs across the board.

Throughout the 1990s, the elderly will likely continue to pay ever larger proportions of their income for health care. Of equal concern is the fact that the Medicare Trust Fund will run out of money by 1990 unless steps are taken to increase income or reduce outlays, or both. Added to these trends are predictions of continued escalation of general health care costs and the coming boom in the elderly population in the next century.

UNANSWERED QUESTIONS

1. Can we deal with the health care costs of the elderly separately from the general health care costs of the country? Should we?

2. What shifts will occur in types of health services needed by tomorrow's elderly?

3. What are the most appropriate roles for the public and private sectors in financing, delivering, and regulating health care?

4. To what extent can the medical profession regulate itself to produce needed quality standards and guidelines, and to what extent should the government be involved in setting those standards and guidelines?

5. Can rationing of necessary health care be avoided? What methods should be used to insure that unnecessary procedures are not done?

6. What can we do to place more emphasis on maintaining good health and preventing disability and illness, as well as treating illness when it develops?

7. How should health care research related to the elderly be balanced with regard to improving life expectancy and improving quality of health life for the elderly?

8. Should the U.S. have some form of national health insurance?

9. To what extent should the federal government insure against catastrophic illness for the elderly? For the population in general?

10. To what extent will alternative health care systems such as Health Maintenance Organizations (HMOs) reduce the rate of growth in health care costs for the elderly?

11. Can we learn from the experiences of other countries in this area?

OPTIONS

The option statements presented on the next few pages are intended to stimulate thought and discussion. They are not comprehensive, nor are they endorsed by the Congressional Clearinghouse on the Future, the House Select Committee on Aging, or any other organization or individual involved in the preparation of this report. Their sole purpose is to introduce the reader to the variety and scope of options that have been raised in this area, so understanding and useful debate will be enhanced.

CAUTION: The options shown here are not endorsed by the House Select Committee on Aging or the Congressional Clearinghouse on the Future; they are presented for information and discussion only.

ISSUE AREA: ALLOCATION OF HEALTH CARE RESOURCES

OBJECTIVE: Improve the financial solvency of Medicare.

ILLUSTRATIVE OPTION 1	ILLUSTRATIVE OPTION 2	ILLUSTRATIVE OPTION 3
Limit payments to Medicare providers (doctors, hospitals) while maintaining quality.	Increase Medicare revenues by increasing payroll taxes or support from general revenue or excise taxes.	Increase use of Health Maintenance Organizations (HMOs) by the elderly.
PROS	**PROS**	**PROS**
1. Care-givers might be more likely to prescribe only essential services. 2. If fixed payment levels were set appropriately, providers would have an incentive to perform services more efficiently.	1. Could help make system solvent without undue burden on the elderly.	1. Could reduce payments made by both the elderly, and the Medicare and Medicaid programs. 2. Allows government to insure better quality assurance by providers. 3. Allows providers to have stronger role in allocating resources among health services.
CONS	**CONS**	**CONS**
1. Market may be better than government at setting payment levels: - if payments too high, further waste would result - if payments too low, providers could refuse to serve Medicare patients. 2. Quality of care may still be compromised.	1. Could be a drag on employment of new workers. 2. Could reduce emphasis on cost constraints. 3. Not a solution to the problem of increasing costs.	1. Elderly unfamiliar with HMOs and how they operate. 2. Might require some short-term federal investment if HMOs were to reach large numbers of elderly.

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ISSUE AREA: ALLOCATION OF HEALTH CARE RESOURCES

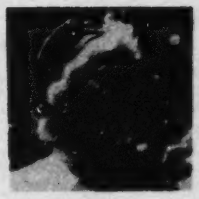
OBJECTIVE: Increase quality of life for tomorrow's elderly.		OBJECTIVE: Improve health services to the elderly and improve equity of access.
ILLUSTRATIVE OPTION 1	**ILLUSTRATIVE OPTION 2**	**ILLUSTRATIVE OPTION 1**
Increase emphasis on preventive health care for all Americans (e.g. exercise, nutrition, stress reduction).	Support research into the risks and benefits of specific medical and surgical interventions for the elderly.	Contain out-of-pocket health care costs to the elderly.
PROS	**PROS**	**PROS**
1. Tomorrow's elderly possibly could have fewer health problems. 2. Long-term costs could be reduced if health problems decreased in consequence.	1. Would provide better basis for decision-making by the elderly, physicians and policy-makers. 2. Could provide more cost-effective basis for practice of medicine to the elderly.	1. Could relieve pressure on expenditures for other necessities, e.g., food, shelter. 2. Could give elderly opportunity to substitute ambulatory care for more expensive hospital care.
CONS	**CONS**	**CONS**
1. Could increase costs in short term. 2. Additional research would be needed as to effectiveness of preventive measures against chronic diseases.	1. Would increase short-term costs.	1. Would increase Medicare costs unless system-wide cost containment occurred.

CAUTION: The options shown here are not endorsed by the House Select Committee on Aging or the Congressional Clearinghouse on the Future; they are presented for information and discussion only.

ISSUE AREA: ALLOCATION OF HEALTH CARE RESOURCES

OBJECTIVE: Improve health services to the elderly and improve equity of access.

ILLUSTRATIVE OPTION 2	ILLUSTRATIVE OPTION 3	ILLUSTRATIVE OPTION 4
Authorize Public Health Service (PHS) fellowships in geriatrics and related specialties.	Provide incentives for home delivery of health services (e.g., shots) to elderly.	Provide incentives to private sector and/or Public Health Service to improve health services in geographical areas now underserved.
PROS	**PROS**	**PROS**
1. Could increase attention to diseases of the elderly by tomorrow's physicians and researchers. 2. Would elicit more research on topics related to elderly.	1. Could be more cost-effective. 2. Would enhance coverage. 3. Would be more convenient for those with restricted mobility.	1. Would enhance coverage. 2. Would improve access for those with restricted mobility. 3. Could improve access to poor and near poor in these areas.
CONS	**CONS**	**CONS**
1. Could cost more. 2. Some experts favor opposite approach, i.e. integrating geriatrics into general medicine. 3. PHS fellowship being questioned as effective incentive to specialization.	1. Could be hard to administer.	1. Could cost more. 2. Could be difficult to maintain any services beyond basic health services since sufficient professional staffing might not be available to meet all the needs.



Tomorrow's Elderly

CHAPTER FOUR

LONG-TERM CARE

The discussion of long-term care for the elderly is commonly presented as part of health care issues. It is treated separately here because it may be more accurate to think of long-term care as helping people live their lives rather than as extended medical care. It is also included as an example of an area in which Medicare and Medicaid reimbursement has built-in biases toward medical treatment and institutionalization, and away from family and other home care.

Most people experience some disability (temporary or permanent) during their lives. This universality of experience may help us to understand the long-term needs of the elderly who are more likely than the general population to have such disabilities. Very frequently, these disabilities result in major requirements not for medical care, but rather for assistance with everyday living.

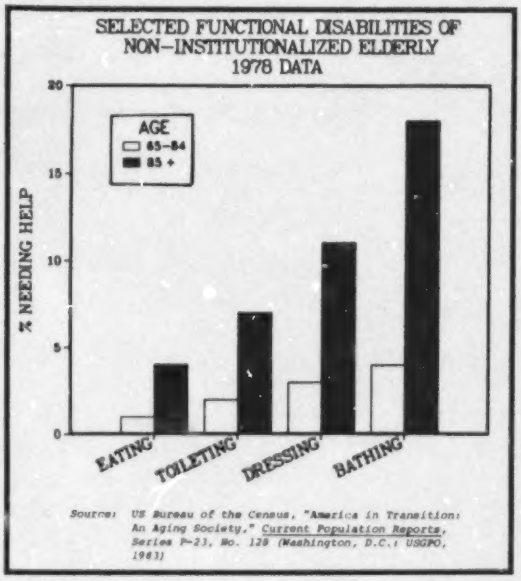
WHAT ARE THE FACTS?

LONG-TERM CARE REQUIREMENTS ARE NOT NECESSARILY MEDICAL

"Long-term care" includes all the services that are needed on a continuing basis to enable a person with a chronic disability to have full physical, social, and psychological functioning.

The existence of such needs does not necessarily imply the presence of a chronic disease. Any limitation in physical and/or mental capacity can prevent a person from accomplishing the tasks of daily living without assistance.

Estimates of the numbers of non-institutionalized elderly who have functional disabilities vary from about 18 percent to 43 percent. While most of these elderly require only limited and unskilled help, this group includes over two million bedfast or housebound persons who are as functionally impaired as those in institutions.



WHAT ARE THE FACTS?

MOST LONG-TERM CARE IS GIVEN AT HOME BY THE FAMILY

In 1980, almost 11 million elderly had some degree of limitation of daily activity due to chronic conditions; less than one in ten of them was in an institution.

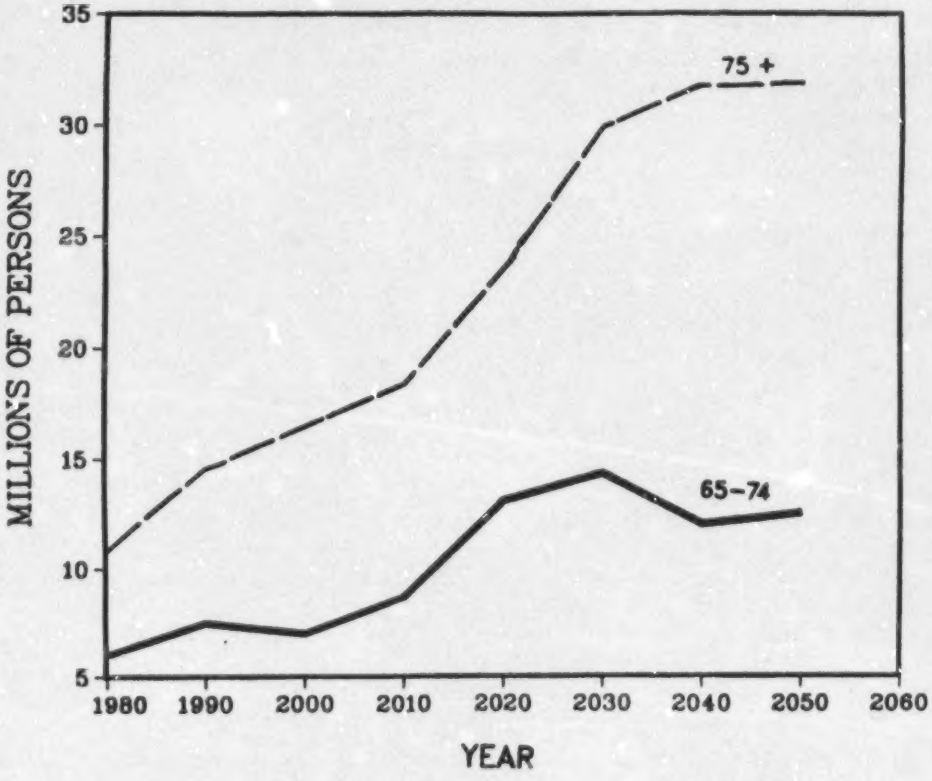
The number with such limitations is expected to rise to over 16 million by the year 2000, and exceed 23 million by 2020 — more than double the current level.

The vast majority of long-term care of these non-institutionalized elderly is provided by family and friends. Seventy-three percent of elderly home care is provided solely by relatives and another 16 percent use formal sources to supplement family care. As would be expected, those living alone or with non-relatives make greater use of formal care services than do those who live with relatives.

As demands for care increase in intensity or complexity, family care tends to be supplemented by outside help which must be paid for but is still not necessarily medical in nature (for example, transportation, food services, and personal companions).

The primary factor leading to institutionalization of an older person is not health status. Institutionalization results from absence of family, exhaustion of personal or family resources, or the over-accumulation of burden on existing family members.

LIMITATION IN ACTIVITY DUE TO CHRONIC CONDITIONS ACTUAL AND PROJECTED



Source: Based on 1980 Health Interview Surveys National Center for Health Statistics; and US Bureau of the Census, "Projections of the US: 1982-2050," Current Population Reports, Series P-25, No. 922 (Washington, D.C.: USGPO, 1982)

WHAT ARE THE FACTS?

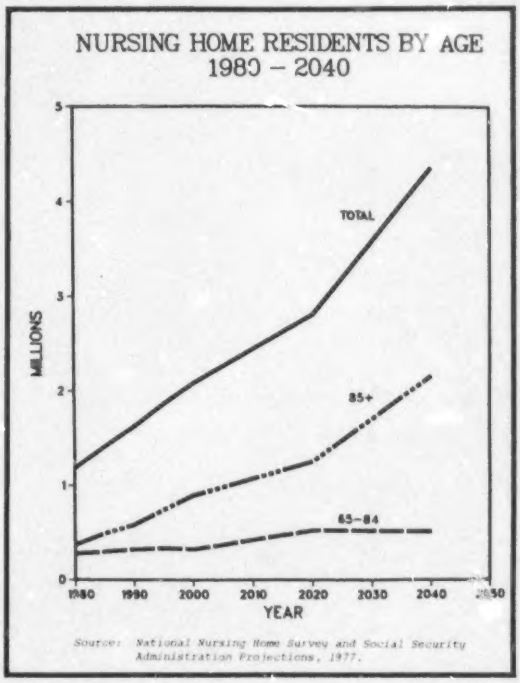
DEMAND FOR NURSING HOME CARE IS RISING FASTER THAN SUPPLY

Even though only about 5 percent of the elderly live in nursing homes at any given time, the rate of use of nursing homes by the elderly has almost doubled since the introduction of Medicare and Medicaid.

Roughly 20 percent of the very old are institutionalized. Most of these are women. The number of people needing institutional nursing care is growing:

- At the beginning of this century, the most prevalent health problems of the elderly were acute. Today, the most prevalent health problems are chronic, and the likelihood of having a chronic illness or a disabling condition increases dramatically with age.
- Women predominate in the 85+ population — the population in highest need of long-term care.
- The diseases which affect elderly men tend to kill. The diseases which affect elderly women tend to cause chronic illnesses and conditions requiring assistance.
- Elderly women are much more likely to be widowed and to live alone than elderly men, and thus to need outside help for disabilities.

Nursing homes are mostly "for profit", and generally full. It seems likely that there will be a growing problem of meeting the demand for nursing home care, particularly for those with the greatest need — the very old, blacks, and the very poor.



WHY IS THIS ISSUE DIFFICULT?

GOVERNMENT LONG-TERM CARE SUPPORT IS BIASED TOWARDS INSTITUTIONALIZATION

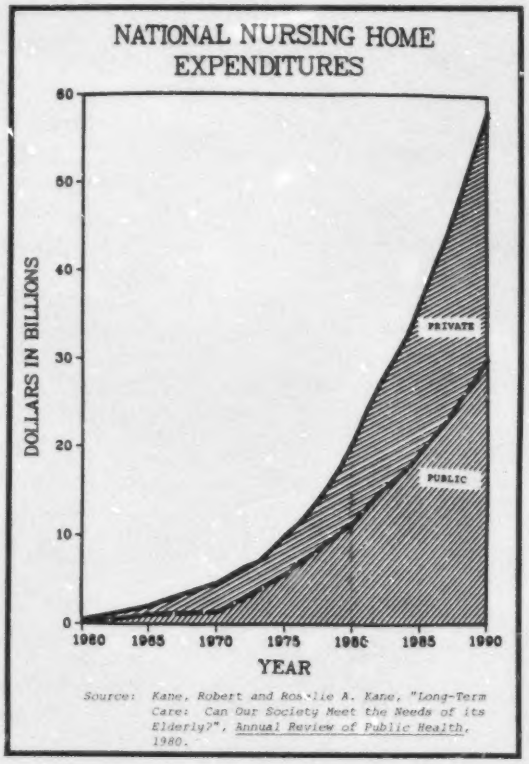
The issue of who pays for long-term care is highly dependent on whether the care is at home or in an institution. Public financial support for long-term care is scarce outside nursing homes. Home care, especially that provided by homemakers rather than by nursing personnel, is rarely covered except in demonstration projects. Day care services for the elderly are similarly not covered by public funds.

While most funding for long-term care comes from the elderly and their families, some public support comes from Medicaid and a minimal contribution is made by Medicare.

Despite some recent efforts to counteract the bias, both Medicare and Medicaid pay more toward institutional costs than home care costs. Since the elderly's out-of-pocket costs for purchased home care services are generally much higher than for the same services performed in a nursing home or hospital, there is a financial incentive to place the person in an institution. As a result, many elderly people in nursing homes are receiving a higher level of care than their condition requires — between 10 and 45 percent depending on the type of nursing facility.

Since 1974, government and private payments for nursing home care have grown dramatically and are expected to continue to escalate for the foreseeable future. Private spending, in the form of health insurance, and personal and family resources, accounts for about half of the total costs of nursing care.

While it is generally agreed that the cost of nursing home care is becoming too large, there is also agreement that government resources need to be reallocated to non-institutional long-term care which may be less costly and frequently more appropriate than institutionalization.



Source: Kane, Robert and Rosalie A. Kane, "Long-Term Care: Can Our Society Meet the Needs of its Elderly?", Annual Review of Public Health, 1980.

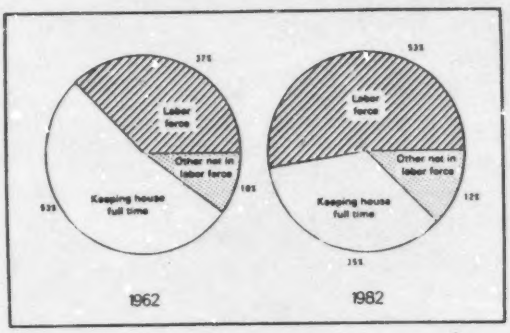
WHY IS THIS ISSUE DIFFICULT?

THE FAMILY MAY NOT BE ABLE TO PROVIDE AS MUCH CARE IN THE FUTURE

At present, the family is the primary provider of long-term care for the non-institutionalized elderly. Yet, demographic and social trends indicate that the family's ability to provide this support will be strained:

- An increasing number of elderly live alone rather than in a family setting (more than 30 percent in 1980). Most of those living alone are women.
- The 85+ population is the fastest growing age group in the United States. This group is much more likely than the rest of the population to need assistance in daily living.
- As life expectancy increases, the trend will be for the very old to have children who are themselves elderly. These elderly children are not as likely to have the financial resources and physical stamina to care for older relatives.
- Younger adult children who are still in the work force may increasingly find that they have more than one generation of elderly relatives to support and assist.
- Family size has decreased markedly over the last 30 years, so there are and will continue to be fewer children to provide assistance for elderly parents.
- Last, and perhaps most importantly, women, the traditional care-givers, are increasingly in the work force rather than at home. Today and in the future, women are less likely to be available as full-time, dependent-care providers for the elderly.

A SMALLER PROPORTION OF WOMEN FILL THE TRADITIONAL FULL-TIME HOUSEKEEPING ROLE



Source: US Bureau of Labor Statistics, Women at Work: A Chartbook, Bulletin 2168 (Washington, D.C.: USGPO, April 1983).

SUMMARY

It is very likely that families will increasingly need and expect public help in providing long-term care for the elderly:

- The number of elderly in need of such care is increasing.
- More and more elderly women are living alone.
- The traditional care-givers, adult women, are increasingly working outside the home and are not as likely to be available for full-time care in the future. However, technology and flexible employment policies that encourage more work at home may act as a counter trend and allow the family to provide more home care.

There is great need for more research on how best to pay for and provide long-term care and to assist decision-making by families or elderly individuals in this area. As one example of the potential value of such research, a recent study has indicated that the existence of community-based services encourages families to continue long-term care of their elderly relatives, rather than choosing institutionalization.

Not only is it more humane to assist elderly people in remaining active members of their families and communities as long as possible, but it is essential if we are to make the most effective use of the limited and expensive institutional care facilities that we have.The growth of the over-65 and over-85 populations alone will be so great as to require the use of all of the existing nursing home facilities just for those who are truly incapacitated and who have no alternatives.

The elderly living alone are a group particularly vulnerable to institutionalization —sometimes for lack of relatively minor but essential services. This group of elderly deserves particular public policy attention.

UNANSWERED QUESTIONS

1. What is and should be included in long-term care?

2. What is the appropriate mix of sources for financing long-term care? Will there be resources or a need for additional government support to meet the long-term care needs of an increasingly vulnerable population?

3. What is the appropriate mix of services and which should be provided by the public and private sectors respectively?

4. How can existing services be better coordinated for greater effectiveness and efficiency? People with long-term care needs who live in the community often require multiple services such as home health care, home-delivered meals, assistance with chores, and transportation. Different services are usually available, if at all, through several different Federal, State, and local programs. Each program is likely to have to be contacted separately and each is likely to have its own eligibility requirements.

5. What policies and programs will enhance the ability and motivation of the family to provide long-term care?

6. Under what circumstances is it more cost-effective to provide home care services to the frail and vulnerable elderly as an alternative to institutionalization?

7. What can we learn from European approaches to long-term care, such as the provision of sheltered housing (independent dwelling units with some housekeeping and/or meal services and with an emergency call-button system)?

8. How can we increase equity of access to long-term care services on the part of the most needy?

9. How can services be located most conveniently for those who need them? For instance, the elderly, like the U.S. population as a whole, are more heavily concentrated in urbanized areas, but the incidence of chronic illness in the elderly is higher in rural areas where services are less available. Also, consolidation of institutional care for veterans, undertaken to reduce costs, has resulted in undue isolation from family and friends.

OPTIONS

The option statements presented on the next few pages are intended to stimulate thought and discussion. They are not comprehensive, nor are they endorsed by the Congressional Clearinghouse on the Future, the House Select Committee on Aging, or any other organization or individual involved in the preparation of this report. Their sole purpose is to introduce the reader to the variety and scope of options that have been raised in this area, so understanding and useful debate will be enhanced.

CAUTION: The options shown here are not endorsed by the House Select Committee on Aging or the Congressional Clearinghouse on the Future; they are presented for information and discussion only.

ISSUE AREA: LONG-TERM CARE

OBJECTIVE: Expand options for functionally disabled elderly.

ILLUSTRATIVE OPTION 1	ILLUSTRATIVE OPTION 2	ILLUSTRATIVE OPTION 3
Revise Medicare regulations to simplify payment for home-based and community care for elderly.	Increase incentives to families to provide/prolong care to their elderly (greater dependent deductions, tax credits, etc.)	Subsidize or pay directly for community alternatives to nursing homes, such as sheltered workshops, day care, halfway houses, senior centers.
PROS	PROS	PROS
1. Could encourage and support family care. 2. Would enhance personal autonomy and dignity of elderly. 3. Could relieve load on nursing homes. 4. Could increase low skill, part time job opportunities.	1. Could encourage and support family care. 2. Would enhance personal autonomy and dignity of elderly. 3. Could relieve load on nursing homes. 4. Could increase low skill, part time job opportunities.	1. Could relieve load on nursing homes. 2. Could increase supply of alternative resources. 3. Could support family care by temporarily relieving family members of responsibility. 4. Could have social benefits for the elderly.
CONS	CONS	CONS
1. Could be hard to administer. 2. Cost-effectiveness only partly demonstrated. 3. If payment for home care replaces non-paid home care rather than institutional care, costs could be very high.	1. Effectiveness of incentives not yet established. 2. Would reduce tax revenues. 3. Would be difficult to establish appropriate levels of compensation. 4. Would be difficult to establish and enforce eligibility requirements.	1. Could increase problems of monitoring and regulation. 2. Overall costs and benefits uncertain. 3. May encourage new users of these services instead of offering alternatives to those who would otherwise enter nursing homes.

CAUTION: The options shown here are not endorsed by the House Select Committee on Aging or the Congressional Clearinghouse on the Future; they are presented for information and discussion only.

ISSUE AREA: LONG-TERM CARE

OBJECTIVE: Improve cost-effectiveness and quality of long-term care.

ILLUSTRATIVE OPTION 1

Government monitoring of nursing homes receiving Medicare monies to insure that patients are receiving appropriate levels of care, e.g., by quality assurance, and patient pre-screening and re-screening.

PROS

1. Could make space available to those most needing service.
2. Could reduce costs by providing more appropriate levels of care.
3. Could reduce costs by reducing the number of new facilities required for the future elderly.

CONS

1. Difficult to monitor.
2. Would require establishment of criteria for evaluation/ screening.
3. Costly to administer.
4. Could be unpopular with nursing home owners.

ILLUSTRATIVE OPTION 2

Improve linkages between acute and long-term care components of the health care system.

PROS

1. Could improve proper placement of elderly in health facilities.
2. Could potentially reduce capital investment for new facilities.

CONS

1. Would reinforce medical model of long-term care rather than social model.

OBJECTIVE: Improve basis for decision-making.

ILLUSTRATIVE OPTION 1.

Study and learn from the extensive experience of the Veterans Administration with long-term care.

PROS

1. Considerable experience available over many years.
2. Solutions to long-term care might involve some linkage between VA and other long-term care systems.

CONS

1. May not be directly applicable to the problems of the population as a whole, especially women.
2. Could reinforce the status quo rather than emphasizing new approaches.

EPILOGUE

This policy primer has presented key characteristics of tomorrow's elderly, major forces molding their future, and significant issues facing decision-makers as they prepare for that future. Some illustrative options were included to give the reader a taste of the kinds of policies advocated by groups who are concerned about issues related to the elderly and who want to correct problems that they see now or coming in the future. This information is intended to provide a future context within which Congress can consider today's policies and programs. Specific legislative proposals will require far more detailed exploration and evaluation than can be encompassed in this document.

Nevertheless, some conclusions can be drawn based on the materials offered here. It is clear that life for tomorrow's elderly will differ from the experience of previous generations. There will be more of them, so their concerns will be of greater significance to the nation as a whole. They will be older and predominantly female, which will change health profiles and needs relative to those of today's elderly. More of them will live alone, changing the nature of their dependence on resources outside of their own households and families. They will be better educated, and the women will have experienced more years of paid employment.

Federal expenditures in support of the elderly have been steadily increasing. Because the elderly population is growing and its needs are changing, the question of affordability of programs is frequently raised. It is even more urgent, and more appropriate, however, to re-examine fundamental concerns which are often overlooked: What will be the needs of America's elderly in the future? What conditions will they face? What is the appropriate role of the government in meeting their needs? What are the most appropriate policies and programs? How can equity be balanced with efficiency? All these questions can be posed in all three of the issue areas highlighted in this report: employment and retirement, allocation of health care resources, and long-term care. These factors need to be considered and debated together with the issue of affordability and more specific, program-oriented alternatives such as those listed here as "options".

No answers or recommendations are offered here for Congressional consideration. This document attempts only to indicate the magnitude, nature and complexity of the salient questions and to provide focus to the Congressional agenda and debate on the future of America's elderly.

LEGISLATIVE HISTORY

Since the 1930s, 85 public laws have been passed that establish public policies toward the elderly. This section presents brief highlights of those years and charts the legislation.

HIGHLIGHTS OF THE LEGISLATIVE HISTORY

The chart below lists major laws by decade; characterizes major impact or intent (income security, health, housing, employment, or social services) and shows other major economic and social trends that were occurring when the legislation passed.

1930-1939: "THE NEW DEAL" PROGRAMS

In the post-Depression period, Congress enacted key legislation for the elderly, such as the Social Security Act of 1935. Under Franklin Roosevelt's New Deal, measures were taken to provide for the poor and assure the economic security of all citizens.

1940-1949: DEFENSE EMPHASIS

During World War II and immediately after, emphasis was on the war effort and providing benefits for the returning veterans. Although there was some acknowledgement of the increase in the elderly population, domestic legislation was put on hold.

1950-1959: POST-WAR DOMESTIC PROGRAM EXPANSION

Following World War II, a broad range of programs was enacted for the construction of housing, schools, and highways. The elderly gained indirectly from these programs, particularly the housing programs and the programs for rehabilitation of the physically handicapped. The Social Security Act was expanded to provide disability benefits.

1960-1969: "THE GREAT SOCIETY" PROGRAMS

During the Lyndon Johnson era, major new social programs for people of all ages were initiated by Congress. This era marked the second great wave of programs benefiting the elderly: Medicare, Medicaid, anti-poverty programs, the Older Americans Act, and others.

1970-1979: PROGRAM CONSOLIDATION AND RESTRUCTURING

During the 1970s, the primary emphasis was on restructuring and consolidating programs. The Nixon Administration sought to decentralize program administration, increase the role of the states, control spending, and build-in accountability. However, SSI, the Federal Government's first nationally administered welfare program was established to provide minimum benefits to the needy aged, blind and disabled, and ERISA enacted in 1974 provided federal standards for protecting private pension programs.

1980-1984: DECELERATION AND COST CONTAINMENT.

The Reagan Administration has stressed private sector initiative, a reduced role for the federal government, reduction of domestic spending, and increased military spending. In response to presidential initiatives, Congress has cut spending and tightened the eligibility requirements for a number of federal domestic programs that benefit the elderly.

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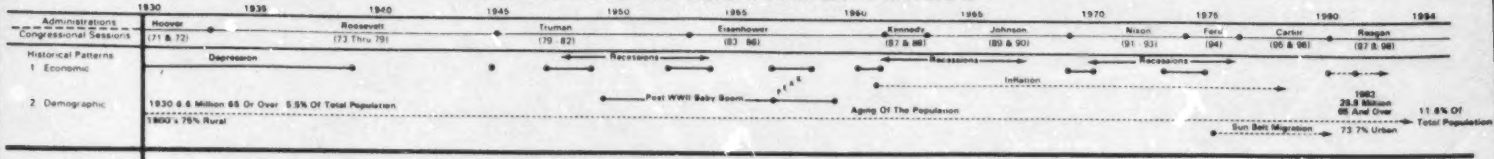
HISTORICAL PATTERNS AND LEGISLATION AFFECTING THE ELDERLY



Legislation	1930–1939 Domestic Program Initiative	1940–1949 Defense Emphasis	1950–1959 Domestic Program Expansion	1960–1969 Great Society Programs	1970–1979 Program Consolidation and Restructuring	1980–1984 Cost Deceleration and Containment
● Income Security	● Civil Service Retirement Act 1930 (Ch. 349, 46 Stat. 468, 479) ● Social Security Act 1935 (PL 74-241) ● Railroad Retirement Act 1935 (Ch. 812, 49 Stat. 967) ● World War Pension Act 1939 (Ch. 331, 53 Stat. 1068)		● Servicemen's and Veterans' Survivor Benefit Act 1956 (Ch. 837, 70 Stat. 857) ● Veterans Pension Act 1959 (PL 86-211)	● Social Security Amendments Old Age Survivors and Disability Insurance Amendment 1965 (PL. 89-97) Title III ● Veterans Pension and Readjustment Assistance Act 1967 (PL. 90-77) ● Federal Coal Mine Health Safety Act 1969 (PL. 91-173)	● Social Security Amendments 1972 (PL. 92-603) ● Employee Retirement Income Security Act 1974 (PL 93-406) ● Veterans and Survivors Pension Adjustment Act 1974 (PL 93-527) ● Social Security Amendments 1977 (PL. 95-216)	● Omnibus Budget Reconciliation Act 1981 (PL. 97-35) ● Social Security Amendments 1983 (PL. 98-21)
● Health	● Social Security Act 1935 (PL 74-241)		● Veterans Benefits 1958 (PL. 85-857) ● Federal Employees Health Benefit Act 1959 (PL. 86-382)	● Community Mental Health Centers Act 1963 (PL. 88-164) ● Social Security Amendments 1965 (PL. 89-97) Medicare Title XVIII Medicaid Title XIX ● Veterans Rehabilitation and Medical Services Modernization Amendments 1966 (PL. 89-785)	● Community Mental Health Centers Amendments 1970 (PL. 91-211) ● Social Security Amendments 1972 (PL. 92-603) Supplemental Security Income (SSI) 1972 ● Veterans Health Care Expansion Act 1973 (PL. 93-82) ● Veterans Omnibus Health Care Act 1976 (PL. 94-581) ● Medicare Medicaid Anti-Fraud and Abuse Amendments 1977 (PL. 95-142) ● Social Security Amendments 1977 (PL. 95-216) ● Older Americans Act Amendments 1978 (PL. 95-478) ● Health Services and Centers Amendments 1978 (PL. 95-626)	● Mental Health Systems Act 1980 (PL. 96-197) ● The Omnibus Budget Reconciliation Act 1980 (PL. 99-499) Title IX ● The Omnibus Budget Reconciliation Act 1981 (PL. 97-35) Title XX ● Tax Equity and Fiscal Accountability Act 1982 (PL. 97-248) ● Veterans Administration Health Care Improvements and Extension Act 1982 (PL. 97-251) ● Social Security Amendments 1983 (PL. 98-21)
● Housing	● National Housing Act 1934 (PL. 73-479) ● U.S. Housing Act 1937 (PL. 75-412)	● Veterans Emergency Housing Act 1946 (Ch. 268, 60 Stat. 207) ● Housing Act 1949 (Ch. 338, 63 Stat. 413)	● Housing Act 1959 (PL. 86-372)	● Housing Act 1961 (PL. 87-70) ● Housing Act 1964 (PL. 88-560) ● Housing and Urban Development Act 1965 (PL. 89-117) ● Housing and Urban Development Act 1968 (PL. 90-448)	● Rehabilitation Act 1973 (PL. 93-112) ● Housing and Urban Development Act 1973 (PL. 93-117) ● Veterans Housing Act 1974 (PL. 93-569) ● Housing and Community Development Act 1974 Title II (PL. 93-383) ● Energy Conservation and Production Act 1976 (PL. 94-385) Title IV ● Veteran Housing Benefits Act 1978 (PL. 95-478)	● Housing Act & Community Development Act 1980 (PL. 96-399) ● Omnibus Budget Reconciliation Act 1981 Title III (PL. 97-35) ● Low Income Home Energy Assistance Act 1981 (PL. 97-35) Title XXVI ● Veterans Disability Compensation Housing and Memorial Amendments 1981 (PL. 97-66) ● Housing and Urban/Rural Recovery Act 1983 (PL. 98-181)
● Employment	● Unemployment Relief 1933 (Ch. 17, 48 Stat. 22) ● Wagner Peyser National Employment System Act 1933 (PL. 73-30) ● Federal Emergency Relief Act 1933 (Ch. 30, 2(b) 48 Stat. 55)	● Employment Act 1946 (PL. 79-304)		● Manpower Development & Training Act 1962 (PL. 87-415) ● Equal Pay Act 1963 (PL. 88-38) ● Economic Opportunity Act 1964 Amended (88-452) ● Older Americans Act 1965 (PL. 89-73) Title IX ● Public Works and Economic Development Act 1965 (PL. 89-136)	● Equal Employment Opportunity Act 1972 (PL. 92-261) ● Comprehensive Employment and Training Act 1973 (PL. 93-203) ● Older Americans Community Service Employment Act 1973 (PL. 93-29) Title IX ● Unemployment Compensation Amendments 1976 (PL. 94-566) ● Age Discrimination in Employment Act Amendments 1978 (PL. 95-256) ● Older Americans Act Amendments 1978 (PL.95-478) Title V	● Omnibus Budget Reconciliation Act 1981 (PL. 97-35) Title VI, Title VII ● Job Training Partnership Act 1982 (PL. 97-300) Title II
● Social Services & Other			● Civil Rights Act 1957 (PL. 85-315)	● Urban Mass Transportation Act 1964 (PL. 88-365) ● Food Stamp Act of 1964 Amended (PL.88-525) ● Older Americans Act 1965 (PL.89-73) ● Age Discrimination Employment Act 1967 (PL. 93-259)	● Older Americans Act Amendments 1973 (PL. 93-29) Title II Administration on Aging ● National Mass Transportation Assistance Act 1974 (PL. 93-503) ● Social Security Act Social Services Amendments 1974 (PL. 93-647) Title XX ● Public Health Service Act Amended 1974 (PL. 93-296) Title III, IV Part A National Institute on Aging Age Discrimination Act 1975 (PL.94-135) Title III ● Comprehensive Older Americans Act Amendments 1978 (PL. 95-478)	● Omnibus Budget Reconciliation Act 1981 (PL. 97-35) Title XXIII Subtitle C ● Older Americans Act Amendments 1981 (PL. 97-115)

BIBLIOGRAPHY

American Association of Retired Persons, Federal and State Legislation Policy. (Washington, D.C.: AARP, 1983).

Brody, E. M., "The Formal Support Network: Congregate Treatment Setting for Residents with Senescent Brain Dysfunction," Conference on the Clinical Aspects of Alzheimer's Disease and Senile Dementia, Bethesda, Maryland, December 1978.

The Budget of the United States Government, Fiscal Year 1985. (Washington, D.C.: USGPO, January 1985).

Butler, Robert, "Today's Senior Citizens: 'Pioneers of New Golden Era'." U.S. News & World Report, Inc., July 1984, pp. 51-53.

Butler, Robert, Why Survive? Being Old in America. (New York: Harper and Row Publishing Co., 1975).

Congressional Budget Office, Baseline Budget Projections for Fiscal Year 1984-1988, Part II, 1983.

Congressional Research Service, Government Division, Unpublished data regarding Percentage Voting in Presidential Elections by Age, for 1964-80.

Consumer Reports, "Will You Ever Collect a Pension?" March 1982.

Demkovich, Linda E., "When a Booming Population of Old Vets Checks in for VA Health Care, Look Out". National Journal, June 2, 1984.

EBRI Issue Brief, "Individual Retirement Accounts: Characteristics and Policy Implications," Employee Benefit Research Institute, Washington, D.C., July 1984.

Fallows, James, Washington Editor of the Atlantic Monthly, at Young Peoples Caucus Briefing on the Future of Social Security, (Washington, D.C., April 1984).

Freeland, M. and Schendler, C., "Health Spending in the 1980s: Integration of Clinical Practice and Patterns with Management", Health Care Financing Review, Spring 1984, Vol. 5. No. 3.

Fullerton, Howard N., and Tschetter, John, "The 1995 Labor Force; A Second Look." Monthly Labor Review, Bureau of Statistics, November 1983.

Gelfand, Donald E. and Olson, Jody K., The Aging Network — Programs and Services, (New York, N.Y.: Springer Publishing Co., 1980).

Gornick, M. Medicare Patients: Geographic Differences in Hospital Discharge Rates and Multiple Stays. DHEW Publication No. (SSA) 77-11700 (Washington, D.C. USGPO, June 1977).

Greenough, William C. and King, Francis P., Pension Plans and Public Policy, (New York, N.Y.: Columbia University Press, 1976).

Harrington, M., The Other America, (New York, N.Y.: McMillan Co., 1963).

Health Care Financing Administration, Long Term Care: Background and Future Directions, HCFA 81-20047 (Washington, D.C.: HCFA, January 1981).

Health Care Financing Administration, Bureau of Data Management and Strategy, Personal Correspondence on Medicaid Data Supplement: Expenditures by Recipient Categories, November 1983.

Hobbie, Richard A., "Distribution of Individual Retirement Arrangements by Adjusted Gross Income," Congressional Research Service, The Library of Congress, April 4, 1984.

Kane, Robert L. and Rosalie A., "Long-term Care: Can Our Society Meet the Needs of Its Elderly?". Annual Review of Public Health, 1980.

Kovar, M., Expenditures for the Medical Care of Elderly People Living in the Community Throughout 1980, National Medical Care Utilization and Expenditure Survey, Data Report No. 4, DHHS Publication No. 84-20000, National Center for Health Statistics, Public Health Service (Washington, D.C.: USGPO, November 1983).

Lammers, William W., Public Policy and the Aging, (Washington, D.C.: CQ Press, 1983).

Lubitz, Janet and Prihoda, R., "Use and Costs of Medicare Services in the Last Years of Life,"Health Care Financing Review, Spring 1984, Vol. 5., No. 3.

Macrae, N., "Health Care International", The Economist, April 28, 1984.

Marshall, Ray, Work and Women in the 1980s: A Perspective on Basic Trends Affecting Women's Jobs and Job Opportunities, Women's Research and Education Institute of the Congressional Caucus for Women's Issues (Washington, D.C.: 1983).

McCarthy, Kevin F., The Elderly Population's Changing Spatial Distribution: Patterns of Change Since 1960, R-2916-NIA, (September 1983).

Minnesota Health Profiles 1982: Altkin County, Minnesota Center for Health Statistics, 1982

Morrell, Alice, "Employee Benefit and the Tax Breaks," New England Economic Review, Federal Reserve Board of Boston, January/February, 1984.

Mueller Smith, Marjorie and Robert Gibson, "Age Differences in Health Care Spending," Social Security Bulletin, (various years).

Myers, Robert J., Social Security. (Homewood, Illinois: McCahan Foundation, 1975).

National Center for Health Statistics, "Current Estimates from the Health Interview Survey: 1980." Vital and Health Statistics, Series 10, 1981.

National Nursing Home Survey & Social Security Administration Projections, 1977.

Office of Management and Budget, Federal Expenditures on Programs Benefitting the Elderly — Tables.

Office of Technology Assessment, Computerized Manufacturing Automation: Employment, Education and the Work Place, GPO No. 052-003-00949-8. May 1984.

Office of Technology Assessment, Medical Technology and Costs of the Medicare Program, OTA-H-227, (Washington, D.C.: U.S. Congress, July 1984).

Pancheri, Michael P. and Flynn, David H., The IRA Handbook (Piscataway, N.J.: New Century Publishers, Inc. 1984).

"Pensions After 2000", The Economist, May 19, 1984.

Popa, Mary, "Employers Made Early Retirement More Attractive: Fourth of Surveyed Companies Offer Incentives", Employees Benefit Plan Review, February 1983.

Public Retirement Systems: Crucial to the Southern Economy?, Federal Reserve Bank of Atlanta, July 1983.

"Relative Contribution of Retirement Income Sources," President's Commission on Pension Policy, Final Report, February 1981.

"Relative Importance of Various Sources of the Aged," Social Security Bulletin, Vol. 46, 1983.

Ross, S.G., "Private Sector & Retirement Security: The Need for Comprehensive National Income Security Policy," National Journal, March 31, 1984.

Roos, N.P., Shapiro E., and Roos, L.L., "Aging and the Demand for Health Services: Which Aged and Whose Demand?," The Gerontologist, Vol 24, No. 1, 1984.

Scanlon, William J., "A Theory of the Nursing Home Market," Inquiry, Vol. 17:1, Spring 1980.

Schultz, James H., The Economics of Aging, 2nd Edition (Balmont, California: Wadsworth Publishing Company, 1980).

Smith, Shirley and Francis W. Horvath, New Developments in Multistate Working Life Tables, Bureau of Labor Statistics (Washington, D.C.: USGPO).

Soldo, Beth J., A National Perspective on the Home Care Population, CPR83-004 (Washington, D.C.: Georgetown University, November 1983).

Soldo, Beth J., "America's Elderly in the 1980s", Population Bulletin, Vol 35, No. 4 (Washington, D.C.: Population Reference Bureau, November 1980).

Sourcebook on Aging. (Chicago, Illinois: Marquis Academic Media, 1977).

Survey of Current Business, "Employees Contributions", Vol. 163, July 1983.

Statistical Abstract of the United States, 1983 Edition, (Washington, D.C.: USGPO, 1983).

Steinitz, Lucy, Y., "Informal Supports in Long-Term Care: Implications and Policy Options", prepared for the Administration on Aging, Health and Human Services, and the National Conference on Social Welfare, February 1981.

United States Code Annotated General Index Table of Acts by Popular Name. (St. Paul, Minnesota: West Publishing Company, 1980).

U.S. Department of Commerce, Bureau of the Census, Aging Population Division, Unpublished data regarding poverty rates of selected groups in the population: 1966-1982.

U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-25, No. 922; P-25, No. 937; P-25, No. 917 (Washington, D.C.: USGPO, various years).

U.S. Department of Commerce, Bureau of the Census, "A Profile Analysis of Minnesota Counties," (Washington, D.C.: USGPO, 1979).

U.S. Department of Commerce, Bureau of the Census, "America in Transition: An Aging Society", Current Population Reports Special Studies, Series P-23, No. 128 (Washington, D.C.: USGPO, September 1983).

U.S. Department of Commerce, Bureau of the Census, "Characteristics of Households and Persons Receiving Selected Noncash Benefits", Current Population Reports, Series P-60 (Washington, D.C.: USGPO, various years).

U.S. Department of Commerce, Bureau of the Census, Decennial Census Book, 1980 Census Population," Current Population Reports, (Washington, D.C.: USGPO, 1980.

U.S. Department of Commerce, Bureau of the Census, "Health Interview Survey — Middle Series Projections," Current Population Reports, Series P-25, No. 922 (Washington, D.C.: USGPO, 1984).

U.S. Department of Commerce, Bureau of the Census, "Historical Statistics of the U.S., Part 1," Current Population Reports (Washington, D.C.: USGPO, 1975).

U.S. Department of Commerce, Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States," Current Population Reports, Series P-60, No. 137; P-60, No. 132 (Washington, D.C.: USGPO, various years).

U.S. Department of Commerce, Bureau of the Census, "Population Profile of the U.S. 1980," Current Population Reports, Series P-20, No. 363 (Washington, D.C.: USGPO, 1981).

U.S. Department of Commerce, Bureau of the Census, "Provisional Projections of the Population of States by Age and Sex: 1980-2000," Current Population Reports, Series P-25, No. 937 (Washington, D.C.: USGPO).

U.S. Department of Commerce, Bureau of the Census, "Social Statistics for the Elderly," (Washington, D.C.: USGPO, 1975).

U.S. Department of Commerce, Bureau of the Census, "Southern California Information System Project: 1971," (Washington, D.C.: USGPO, 1971).

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Education, Working Papers in Long-Term Care (Washington, D.C.: October 1981).

U.S. Department of Health and Human Services, "Expenditure for the Medical Care of Elderly People Living in the Community Throughout 1980," National Medical Utilization and Expenditure Survey, Data Report, No. 4, DHHS No. 84-2000 (Washington, D.C.: USGPO, November 1983).

U.S. Department of Labor, Bureau of Labor Statistics, Employee Benefits in Medium and Large Firms: 1982, Bulletin 2176 (Washington, D.C.: USGPO, 1983).

U.S. Department of Labor, Bureau of Labor Statistics, New Worklife Estimates, Bulletin 2157 (Washington, D.C.: USGPO, 1982).

U.S. Department of Labor, Bureau of Labor Statistics, Recent Trends in Labor Force Participation Rates: A Chartbook (Washington, D.C.: USGPO, 1980).

U.S. Department of Labor, Bureau of Labor Statistics, "Women at Work: A Chartbook," Bulletin 2168 (Washington, D.C.: USGPO, 1983).

U.S. General Accounting Office, A Budgetary Look at Our Nation's Outlays for Older Americans. Washington, D.C., USGAO (unpublished) 1983.

U.S. General Accounting Office, Demographic and Economic Characteristics of Social Security Retiree Families, GAO/HRD-82-131, September 1982.

U.S. General Accounting Office, An Historical Perspective of the Shaping of the Federal Budget, Comptroller General's Consultant Panel, Washington, D.C. (unpublished) 1982.

U.S. General Accounting Office, Health Care Services, Washington, D.C. (unpublished) 1982.

U.S. General Accounting Office, Assessment of the Use of Tax Credits for Families Who Provide Health Care to Disabled Elderly Relatives, GAO/IPE- 82-7, August 1982.

U.S. General Accounting Office, Medicaid and Nursing Home Care: Cost Increases and the Need for Services are Creating Problems for the States and the Elderly, GAO/IPE-84-1, October 1983.

U.S. General Accounting Office, The Elderly Should Benefit from Expanded Home Health Services, But Increasing These Services Will Not Insure Cost Reductions, GAO/IPE-83-1, December 1982.

U.S. General Accounting Office Calculations Based on Veterans Administration Medical Care Data & Bureau of Economic Analysis Implicit Price Deflation, 1982.

U.S. House of Representatives, Select Committee on Children, Youth & Families, Demographic and Social Trends: Implications for Federal Support of Dependent Care Services for Children and the Elderly (Washington, D.C.: USGPO, 1984).

U.S. House of Representatives, Subcommittee on Health, Committee on Ways and Means, Proceedings of the Conference on the Future of Medicare, WMCP: 98-23 (Washington, D.C.: USGPO, February 1984).

U.S. Senate, Special Committee on Aging, Developments in Aging: 1983, Volume 1 (Washington,, D.C.: USGPO, 1984).

U.S. Senate, Special Committee on Aging, Medicare and the Health Costs of Older Americans: The Extent and Effects of Cost Sharing (Washington, D.C.: USGPO, 1984.

U.S. Senate, Special Committee on Aging and the American Association of Retired Persons, Aging America: Trends and Projections (Washington, D.C.: AARP, 1984).

United States Statutes at Large (Washington, D.C.: USGPO, 1930-1978).

Veterans Administration, Caring for the Older Veteran, (Washington, D.C.: VA, July 1984).

Veterans Administration, Veteran population 85 and over: 1980-2030, from VA estimates and projections based on 1980 Census data (August 1984).

Waldo, Daniel and Gibson, Robert, Board of Trustees, Federal Hospital & Supplementary Medical Insurance Trust Funds, 1982.

Ward, Russell A., The Aging Experience: An Introduction to Social Gerontology (New York, N.Y.: Harper and Row Publishers, Inc., 1984).

Wennberg, J., Burker, J., and Barnes, B., "The Need for Assessing the Outcome of Common Medical Factors," Annual Review of Public Health, 1980.

Wennberg, J., Gittelson, A., "Variations in Medical Care Among Small Areas", Scientific American, 1982, 246, 120-134.